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MEDICAL SERVICE SECOND TO NONE*

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Being a member of this Society, it is a pleasure for me to have an opportunity to be invited to talk to this medical group and its friends. Being a member of the Medical Staff of the Veterans Administration, it is naturally an added pleasure for me to be invited to talk to a group that is interested and concerned with the medical welfare and care of the war veterans of America . . . a group that is not only interested in the medical care the veteran is receiving at present, but is also interested in the plans that are being evolved to care for him or her in the years to come.

We all remember that day in December, 1941, when the late President Roosevelt requested the Congress to declare a state of war between our government and the governments of Imperial Japan and the Third Reich. Those grim days will always be fresh in our memories. Probably your thoughts then were the same as mine. We wondered what kind of army and navy we had. We wondered how well equipped our country was to wage a total war on two widely separated fronts.

Up until that point the average layman's mind had not been too concerned with military things, and I am afraid that many of us regarded the army and navy as necessary evils, until it became time for us to think in immediate terms of our own self-protection. However, we soon found that when the chips were down, when the need arose, the men and women who were leading and serving in our Armed Forces were equal to the formidable task ahead.

Eventually the war in Europe was brought to a victorious conclusion. A few months later, V-J Day was declared; and less than 15 hours after that President Truman appointed General Omar N. Bradley as Administrator of Veterans Affairs and as head of the Veterans Administration.

*Read by invitation at the annual meeting of the Medical Society of Virginia at Virginia Beach, October 14-16, 1946.

Even before that, however, wounded, sick, weary veterans were pouring back into the States from the war fronts, headed for Army and Navy hospitals. And the officials of the Veterans Administration then began to realize the enormity of the job with which they were faced.

Veterans Hospitals, too, started to receive their share of this great flood of men and women who needed the absolute best in medical care.

Each day the load became heavier. Each day the number of patients at hospitals everywhere increased. And each day the problems of caring for these men and women were multiplied.

During the war years, Veterans Administration Hospitals faced the same problem that beset all other hospitals during that period. They were short of personnel of all types. Many of the doctors and nurses had gone off to war, leaving behind a skeleton staff.

Just one year ago there were over 1,700 army and navy doctors serving on special detail in Veterans Administration hospitals. This, of course, is a temporary measure adopted to help relieve the critical personnel shortage. In August, of 1945, General Bradley appointed General Paul R. Hawley, former Chief Surgeon in the European Theatre of Operations, as his Director of Medicine and Surgery. Hawley immediately announced that the goal for veterans in Veterans Administration hospitals was "MEDICAL CARE SECOND TO NONE". And with each succeeding day we try to reach nearer that goal.

During the last year the two most difficult problems faced by the Medical Service of the Veterans Administration were the twin-spectres of *personnel* and *space*. The former is well on its way towards being solved. Many highly-capable, well-qualified doctors, dentists, and nurses have answered the call of the deserving veteran and joined the ranks of the Veterans Administration. The latter problem is one

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that will continue to plague us for some time, although heartening progress has been made in solving this problem.

The hospital construction program of the Veterans Administration continues apace. Through the acquisition of Army and Navy hospitals, contracts with private institutions, and the Veterans Administration construction program, hundreds of hospital beds have been added to our quota.

As I said, this problem will be with us for the next year or so, but it is one that we are confident can be solved.

Somewhat less than a year ago a special act of Congress created the Department of Medicine and surgery as an integral part of the Veterans Administration. This act takes professional personnel away from the control of Civil Service regulations except for certain provisions such as vacations and retirement, and places them entirely under the supervision of Dr. Hawley.

One of the biggest changes brought about by the creation of this new department is the fact that doctors who join the Veterans Administration can now be classified and paid according to their professional ability and standing.

Heretofore under Civil Service regulations, the Veterans Administration was required to place a man in a particular position and then pay him a salary that had been established for that position. In effect, we can now award a man a salary more in proportion to his actual ability, rather than be forced to wait for vacancies to occur along the line so that able men can be more adequately compensated.

All of these things we feel are bringing us closer to our objective of providing medical care second to none for the veterans of America. And yet these things are in themselves only a beginning, and I am sure it is not necessary to try to impress upon you the necessity of continuing this work with sustained energy and efforts.

The Veterans Administration furnishes medical care for veterans with service-connected disabilities and with non-service connected illnesses.

Men and women who served in the Armed Forces and who are discharged with a service-connected disability can be furnished hospitalization or out-patient care regardless of their financial status. However, veterans with non-service-connected illnesses who cannot pay for treatment may be given hospitalization in VA hospitals, provided there is a vacancy that is not required by a veteran with a service-connected disability.

To return for a moment for a few words about Veterans Administration Hospital Construction Program, I would like to point out that because the Veterans Administration has over 20,000,000 potential patients, we have embarked upon the world's largest hospital construction program, which, according to present planning, will result in the Veterans Administration operating around 200 hospitals. In Virginia alone at the present time there are well over 2,500 veterans in the three Veterans Administration hospitals in the State . . . Roanoke, Kecoughtan and McGuire. In these three institutions there are some 255 doctors and 30 dentists, many of whom are present this evening.

To cite an example of the patient load the Veterans Administration hospitals are currently bearing, and which incidentally we expect to increase, I would like to offer a few figures of the patient population at McGuire VA Hospital in Richmond. Dr. Edmund M. Ellerson, Manager of the institution, has said, and I quote: "McGuire Hospital, besides being a hospital of general medicine and surgery, has 200 tuberculous cases, about 100 acute neuropsychiatrics and approximately 140 paraplegics. Of the 1,000 available beds at McGuire, 755 are occupied . . . 60 are on trial visit, 96 are committed, which leaves us a reserve of about 90 beds." Dr. Ellerson went on to say that we must have more space shortly. He said that 2,800 patients had been admitted since VA took over McGuire from the Army last April. Eighteen days is the average stay of a patient at McGuire as compared to the Branch Area average of 29 days.

McGuire in Richmond is primarily a general medical hospital; however, it has some of the most modern and up-to-date equipment for the treatment of paraplegic patients of any hospital in the country.

Roanoke VA hospital is primarily an NP hospital; however, a number of beds there are allotted to tuberculous patients, many of whom are also neuro-psychiatrics.

The VA Home at Kecoughtan is primarily for general medical services, but, once again, a number of beds have been allotted to tuberculous patients.

While we do need more doctors, more consultants and more nurses in our hospitals throughout the Branch Area which includes the states of Maryland, North Carolina, Virginia, West Virginia and the

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District of Columbia, each hospital is staffed with the necessary specialists in the various fields.

I am sure you are all familiar with the Residency Training Program that has been inaugurated under the direction of Dr. Hawley in many Veterans Administration hospitals. However, to touch briefly upon it, one of the most important points in this program is the magnificent cooperation that we have received through the work of the various Deans' Committees. These committees are composed of professional men in local medical schools who assist us in selecting young doctors to train as residents; and in providing the consultants to work with the staffs of our hospitals.

As has been said many times by both Dr. Hawley and General Bradley, Veterans Administration hospitals and the VA Medical Program in general could not hope to succeed without the cooperation of the medical profession of America. And, ladies and gentlemen, that cooperation has been evident in all of our work.

Recently Dr. Hawley announced that home town medical care for veterans with service-connected disabilities would soon be available in twenty states. This program is already in operation in 13 states and we hope that soon many more will be participating in the program. As this is one of the most important steps achieved in the Veterans Administration Medical Staff, I would like to explain it in some detail.

Home town medical care will be available to veterans with service-connected disabilities only when Veterans Administration establishments, such as out-patient clinics cannot promptly treat veterans or when traveling to them would involve undue hardship on the veteran. For example, a veteran living at Lee Hall, Virginia, may need medical treatment for injury that he received while on active duty in the Army. We can assume that the man does not need hospitalization and that it will be almost impossible for him to travel back and forth to Kecoughtan or to Richmond to receive out-patient care. The proper procedure for the veteran to follow in order to receive home town medical care from his own physician is for him to first visit the nearest VA office for authorization of the number and type of treatments deemed necessary. Then the local physician can be authorized to give those treatments at government expense.

Should this physician find when treating the man that more treatments are necessary than the VA first allotted, or that a different type of treatment is required, he may secure authorization for these by reporting his findings to the VA office.

One important thing that every home town physician must realize is that the veteran seeking treatment must first get his authority from the VA before he asks the doctor for treatment at Government expense. In the event that a veteran comes to you for such treatment, it will be advisable for you to first ascertain whether or not he has received this authority. It is in all cases the veteran's responsibility.

In emergencies the Veterans Administration expects you to treat the veteran as you would any other emergency case. However, either you or the veteran should notify the Veterans Administration officials promptly after the initial treatment if government payment is to be forthcoming.

One important point regarding home town medical treatment for veterans is that prompt swift service can be obtained from the Veterans Administration if the VA is furnished complete information about the veteran-patient seeking hospitalization, or out-patient treatment, as quickly as possible. We realize too well that in emergencies, the family physician may inherit the task of establishing the patient's eligibility for care by, or at the expense of, the VA.

Much time can be saved by the local physician, however, if he can first obtain the basic facts concerning the origin of the veteran's disability and the type of discharge from service that he received, before a request is made for authorization for treatment or hospitalization. If this is impractical because of an emergency situation, as we discussed before, the physician should get in touch with the proper VA office either by telephone or telegraph as soon as possible. Again I say, the delay in notifying the proper officials may make reimbursement by the Government impossible.

When this plan for home town medical care becomes effective in Virginia, the Veterans Administration Regional Office will be authorized to accept collect calls and telegrams from physicians regarding emergency cases. If the status of the veteran's disability is questionable, the VA will authorize pay for emergency care pending final decision of the veteran's claim. It has been determined that no veteran will be eligible for out-patient treatment or hospitalization in other than a Veterans Adminis-

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tration hospital, unless the disability for which such care is desired is service-connected or service-aggravated to a degree deemed pensionable by the Veterans Administration. However, such care for non-service disability will be provided if that disability adversely affects a service-connected condition.

Regarding admission requirements to VA hospitals, I would like to point out that veterans of both war and peace-time service may be hospitalized in VA facilities. A veteran of war service is entitled to hospitalization for non-service-connected disabilities, if his discharge from the service is other than dishonorable, if a hospital bed is available and not required for a veteran with a service-connected disability, and, finally, if the veteran shows that he is unable to pay the costs of transportation and hospitalization in a civilian hospital.

A peace-time veteran may be hospitalized for a non-service-connected disability provided he has received an honorable discharge from his last period of service, or if he received a discharge for a disability incurred in line of duty, or if he is receiving a pension for service-connected disability and does not have any other adequate means of support.

Regarding women veterans, they are subject to exactly the same regulations as male veterans except that admissions to non-VA hospitals may be authorized for non-service-connected disabilities. Obstetrical cases are not considered disabilities for which treatment or hospitalization can be provided by the VA.

At present the Veterans Administration throughout the entire country is operating a total of over 100 hospitals of all types. One of the things that we are striving to do is to establish a teaching program for our medical staff in the majority of these hospitals. So far we feel that our record has been, at least, satisfactory. Within six months after the Department of Medicine and Surgery was established, there were 32 Veterans Administration hospitals conducting this teaching program. During the second six-months period Dr. Hawley has said that our objective is to have between 65 and 70 Veterans Administration hospitals operating this program.

There are, however, many difficulties that must be overcome. One supremely important one is the fact that some of our hospitals are built in such isolated places that it is difficult to get good doctors and good nurses to serve them. As we all know, there is a shortage of doctors and nurses in this country, or at least there is no excess. Very few of them need work so badly that they will accept just any position, and very, very few good doctors will accept isolation in a medical desert. About the only thing we can offer professional personnel at such an institution is a teaching program, and we are working hard to get this started. But a teaching program cannot be inaugurated at such a hospital without a superior teaching staff, and it is most difficult to attract a superior teaching staff to an isolated hospital. One measure that is helping us to work out this situation is by obtaining the part-time assistance of well trained doctors. But to get the assistance of well trained doctors, *we must go to them.* There will never be enough coming to us to give the veteran the high standard of medical care that he deserves.

One encouraging indication that progress is being made has come about in connection with our hospital construction planning. The sites of many of these new hospitals are purposely chosen so as to be close to medical centers and medical schools. Six months ago we frequently "had to sell" the medical schools on the advantages of cooperating with the Veterans Administration program. Latterly, however, we are in a fortunate position, in that grade-A medical schools throughout the country are urgently requesting us to put our new hospitals in their vicinity. It is our aim to keep this happy union in just that sort of mutually agreeable, profitable state.

I do not want to dry out my remarks with a hodgepodge of statistics; however, I think you might be interested in the percentages represented by our patient load at present. Of the patients in all VA hospitals, 51 per cent are neuro-psychiatric cases; 42 per cent are general medical and surgical cases; and 7 per cent are tuberculous.

Of the total patients in all of our hospitals, 39 per cent are World War II veterans and 61 per cent are veterans of other wars, the vast majority being veterans of World War I.

Of all the patients now in hospitals, 35 per cent have service-connected disabilities and 65 per cent have disabilities that are not service-connected. This proportion of service-connection varies widely with the type of disability. For example, 48 per cent of the cases of tuberculosis are service-connected as against 52 per cent non-service-connected. This is due to the very high percentage of service-connected

cases of tuberculosis among the veterans of World War II . . . 77 per cent of their tuberculosis being service-connected, whereas only 18 per cent of the cases of tuberculosis among veterans of other wars are service-connected. This, we feel, is what might be expected when the age distribution of tuberculosis is considered. Of the NP cases, 41 per cent are service-connected and 59 per cent non-service-connected. Here, again, the proportion differs considerably between World War I and World War II veterans. Sixty per cent of neuro-psychiatric cases from World War II are service-connected and 33 per cent from World War I.

I mentioned earlier that the Veterans Administration faced a potential load of 20,000,000 veterans. It is a conservative estimate that there will be sixteen or seventeen million veterans of World War II at the time World War II is officially ended. There are at present just under four million veterans of previous wars. World War II is not yet ended. There are still many thousands in the armed forces that we can expect will be demobilized within the next year. Every person now enlisting in the Army, even though hostilities have ended, is a potential veteran and will receive many of the benefits granted to veterans who served during hostilities. This all means that at the conclusion of World War II throughout the entire country we shall need 150,000 hospital beds to care for all veterans applying for hospitalization. The Veterans Administration present building program contemplates 125,000 beds, which it is estimated will still leave an excess of 25,000 patients who must be cared for in other federal, state or private hospitals.

The increasing need for hospital care as age advances is shown by the fact that at present more than 50,000 hospital beds are occupied from the population of less than 4,000,000 veterans of World War I, compared to the 30,000 hospital beds which are now occupied by the now 10,000,000 veterans of World War II. So, to project the problem 20 or 25 years into the future, if the veterans of World War II require as much as their predecessors, we shall need more than 250,000 hospital beds 20 or 25 years hence.

These few figures, however, are simply an indication of the work that must be accomplished by the Veterans Administration in the years to come. That work will not be accomplished, could not be accomplished, without the full cooperation of the civilian medical profession.

Ladies and gentlemen, I know the Veterans Administration will do its full part. We have only one principle and that one principle we will never violate. All of our time, all of our thought, and all of our energies are predicated on the fact that the veteran must be given the highest type of medical and hospital care available, anywhere in the world.

All arrangements to this end are flexible and they will be adjusted to meet local situations and conditions insofar as the law permits.

I trust that we may all work together to reach this one objective.

Floral Eponym (49)

ESCHSCHOLTZEA

JOHANN FRIDER. ESCHSCHOLTZ, 1793-1831

ESCHSCHOLTZ was born in Dorpat, November 1, 1793 (old style). He graduated in medicine in 1815, his dissertation being "De hydropsum differentiis". He went as ship surgeon with Kotzebue on the brig "Rurik". Upon his return he became prosector and "ausserordentlicher" professor in Dorpat and director of the zoological cabinet. His second voyage with Kotzebue on the ship "Predprijatel" carried him around the world. After 1828 he was "ordentlicher" professor of Anatomy. Kotzebue named a small coral island and a bay on the American side of the Behring Strait for him. A. Chamisso named a new species of plants *Eschscholtzia californica.*

Eschscholtzia is a genus of papaveraceous plants, found throughout the western coast of the United States. They have finely divided leaves and showy yellow or orange colored flowers. They are cultivated as garden annuals under the name of California poppies.

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THE SELECTION OF AN OBSTETRIC FORCEPS TO SUIT THE CASE*

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Given a proper case for delivery with forceps, an operator may select the kind of instrument most suitable for the conditions. Delivery may be accomplished with only one, or at most two varieties of forceps. However, other things being equal, a greater degree of success should be obtained with a knowledge of the advantages, and a discrimination in the use of the various kinds of forceps. There are several kinds of forceps, old and new, that have peculiar advantages under certain conditions.

In delivery with forceps under proper conditions, there are two features of prime importance; the application of the forceps to the child's head, and the traction used in accomplishing the delivery. These two acts determine the manipulation, effort, and, consequently, the associated trauma.

APPLICATION OF FORCEPS

The application must be cephalic and accurate. In a true cephalic or bi-parietal application, the blades should fit the head as accurately as possible. They should lie evenly against the sides of the head, reaching from the parietal bosses to and beyond the malar eminences, covering symmetrically the spaces between the orbits and the ears. There should be no extra pressure at any one point.

A correct application is essential. It prevents injury to the head because the blades fit the head accurately and pressure is evenly distributed; the pressure is on the least vulnerable areas; the increased diameter of the head, due to the thickness of the blades, is at the narrowest place, thereby minimizing the force necessary for delivery.

A correct application lessens injury to the mother because the head advances in the proper attitude. It is vital to the technic of the delivery because it enables the operator to know the exact position of the head, and allows him to use the most favorable diameters. These conditions are not fulfilled by the undesirable brow-mastoid application.

In selecting an instrument with which a good application can be obtained, the choice depends upon a correct diagnosis of the amount of moulding, position and station of the head, and the type of pelvis.

On moulded heads, the best application is obtained with blades which have a long, tapering, cephalic curve. Those with a short, full curve do not fit evenly, causing pressure points, and often are not anchored below the malar eminences, with consequent cutting or slipping.

In considering the position of the head, the instrument to be chosen is the one which gives the correct application with the least effort. When the occiput is anterior, the application is, as a rule, easily made, and any blade which fulfills the requirements of the moulding may be used. For other positions and presentations there are special types which will be considered with the various forceps operations. A high head, in a flat pelvis, may be angulated in such a position that a cephalic application cannot be obtained unless the forceps have a flexible blade.

TRACTION

The traction also plays a very important part in the choice. To use the least force, one should make traction in the pelvic axis. This may be done manually, but is best accomplished in all stations of the head with some form of axis-traction forceps. Even in low forceps, axis traction is valuable in obtaining flexion, and in eliminating the force wasted against the symphysis. The deep episiotomy allows the handles of the forceps to lie in a lower plane. This, with the use of the fingers as a fulcrum, may eliminate the necessity of instrumental axis traction on low heads. However, the axis-traction instrument automatically directs the force away from the symphysis, and thus simulates the physiological mechanism of labor.

Axis traction suggests, to many, a difficult operation with a complicated instrument. For this reason, in the average case it is often neglected, though the advantages are admitted. The classical forceps, without axis traction, are frequently used with the maximum force, reduced manually by the modified

*Read before Southwestern Virginia Medical Society at Radford, October 3, 1946.

Pajot maneuver. Axis-traction forceps, however, tend to keep the force in the plane of least resistance, thereby diminishing the amount of effort and injury.

SELECTION OF INSTRUMENT

In the selection of an instrument which fulfills the requirements of application and traction, there are a number of excellent forceps from which to choose. Some are simple, others complicated. All have one or more good points, which justify their use when properly chosen. Some are so similar that there is very little choice between them. Most modern forceps of the classical type follow, in a general way, one of two constructions: the shanks overlap, the blades have a short, cephalic curve as in the Elliot, or the shanks are separated, and the blades have a long, tapering curve as in the Simpson. (Fig. 1) But not all of them have axis traction. This disadvantage can be overcome in some of the Elliot type by the use of the Bill axis-traction handle.

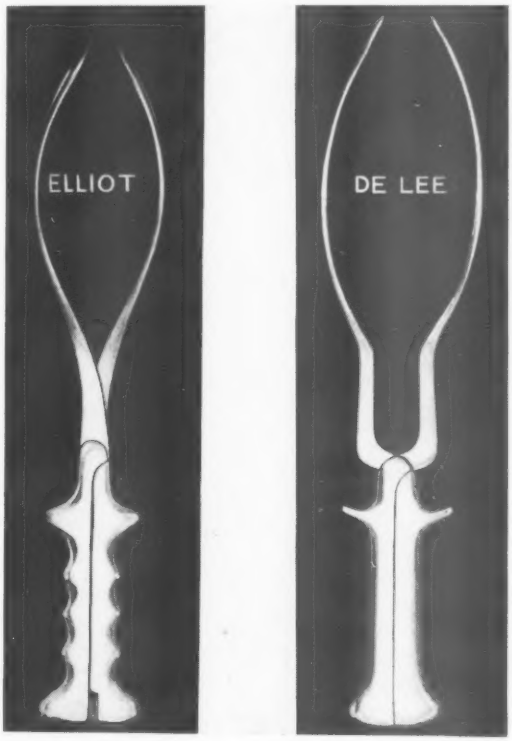

Fig. 1.—Shows difference in construction in the two common types of forceps.

Various localities have their favorites. In Boston and that vicinity, the light Good forceps with the traction rods from the fenestrations, concealed in the handles, are popular. So are Irving's with traction rods similar to Tarnier's, which permit the use of the most accurate line of traction of any axis-traction attachment. In Philadelphia, there is a preference for the DeWees', and Piper's modification of it, with the traction rod attached to the end of one handle. Chicago favors the DeLee modification of the Simpson without axis traction and the Adair with multiple perforations of the solid blades. In New York, several types are used: DeWees', DeLee's, Tucker-McLane's, Bailey-Williamson's, Lobenstein-Tarnier's, Elliot's and Hawks-Dennen's. (Figs. 2, 3, 4) In different parts of the country, the Kielland's and Barton's are gradually increasing in popularity for use on cases with the head not in an anterior position. The interest in both these instruments should continue to grow with the better understanding of their advantages and a thorough knowledge of the technique of their use.

LOW FORCEPS

In a truly low forceps, most heads are in the anterior position. The amount of moulding, and the type of outlet determine the choice of instrument. In pelves with a low pubic arch, and a short anterior posterior diameter of the outlet, it is essential to choose a blade with a good pelvic curve. This will put less pressure on the perineum, and tend to avoid sulcus tears of the vagina during extension. In normal pelves, the important factor is protection of the child's head against cuts and abrasions. Third degree tears are guarded against by frequent use of perineotomy. It is thought that a cut perineum, well repaired, is better than one which is torn or stretched. It also relieves the pressure on the anterior wall.

The mother is, as a rule, a primipara, or perhaps a multipara in long labor. This usually means moulding of the baby's head, with its sides lengthened and flattened. A Simpson type of forceps fits best. It has a long, shallow, cephalic curve, and the tips can be anchored well below the malar eminences, preventing pressure points and slipping. A blade with a short, sharp, cephalic curve, of the Elliot type is suitable for round heads. When considerable moulding is present, it fits unevenly, and

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occasionally gives difficulty in proper locking.

For easy extractions, the solid blades of the Tucker-McLane are popular with some obstetricians. They are easy to apply and remove, and may be used on small round heads. On moulded heads, they may slip, due to lack of anchorage below the malars, and they exert pressure on two points; the zygoma, and parietal boss. The result may be a cut over the zygoma just in front of the ear, and the appearance later of swelling over the boss. The latter is a periostitis which may last for weeks, and occasionally develops into an abscess. Luikart's modification, in which the outline of the fenestration is preserved on the inner surface of the solid blade, minimizes this disadvantage.

Many times, what is thought to be an easy low forceps, later proves to be the caput of a moulded head, the bi-parietal diameter of which is at, or above, the ischial spines. Then the operator wishes he had chosen a fenestrated blade originally. The solid blades are excellent as rotators in the first stage of the Scanzoni maneuver. A suitable fenestrated type may be used for the extraction.

To simplify the choice of instrument for anterior positions of the occiput at any station in the pelvis, an uncomplicated, light, fixed axis-traction forceps

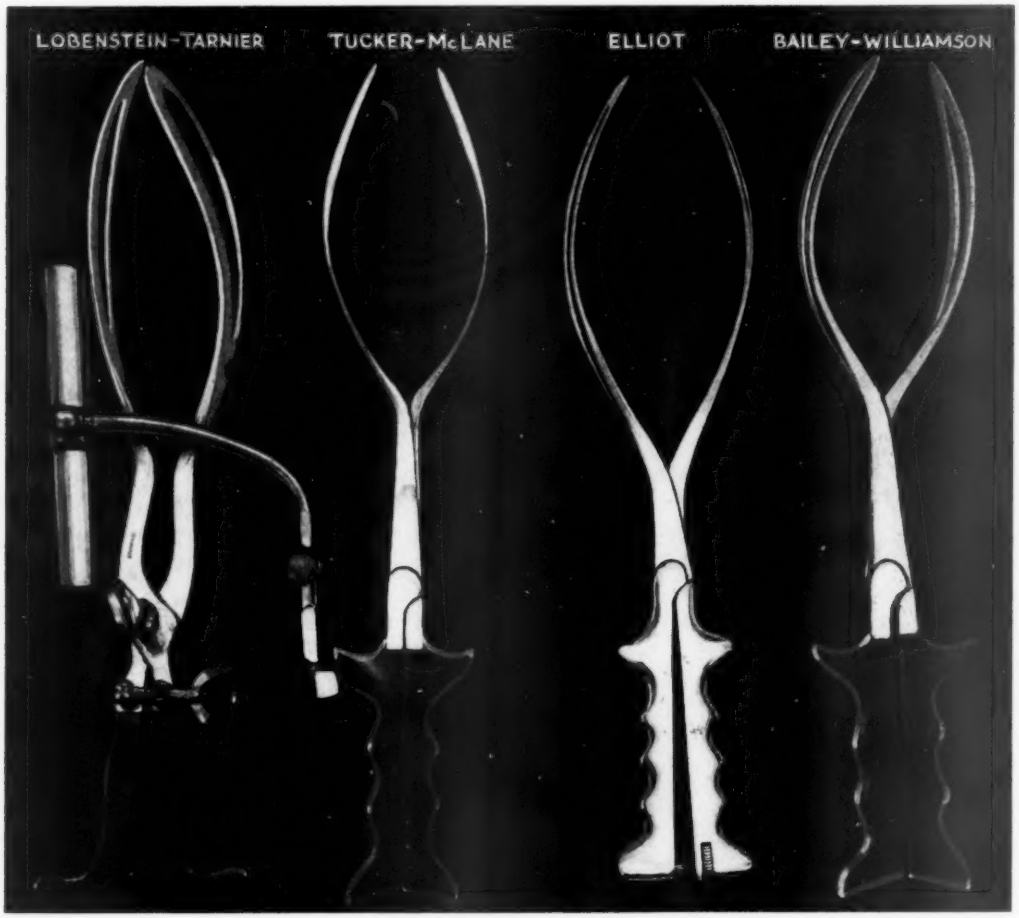

Fig. 2.—Shows Elliot Types (except Tarnier).

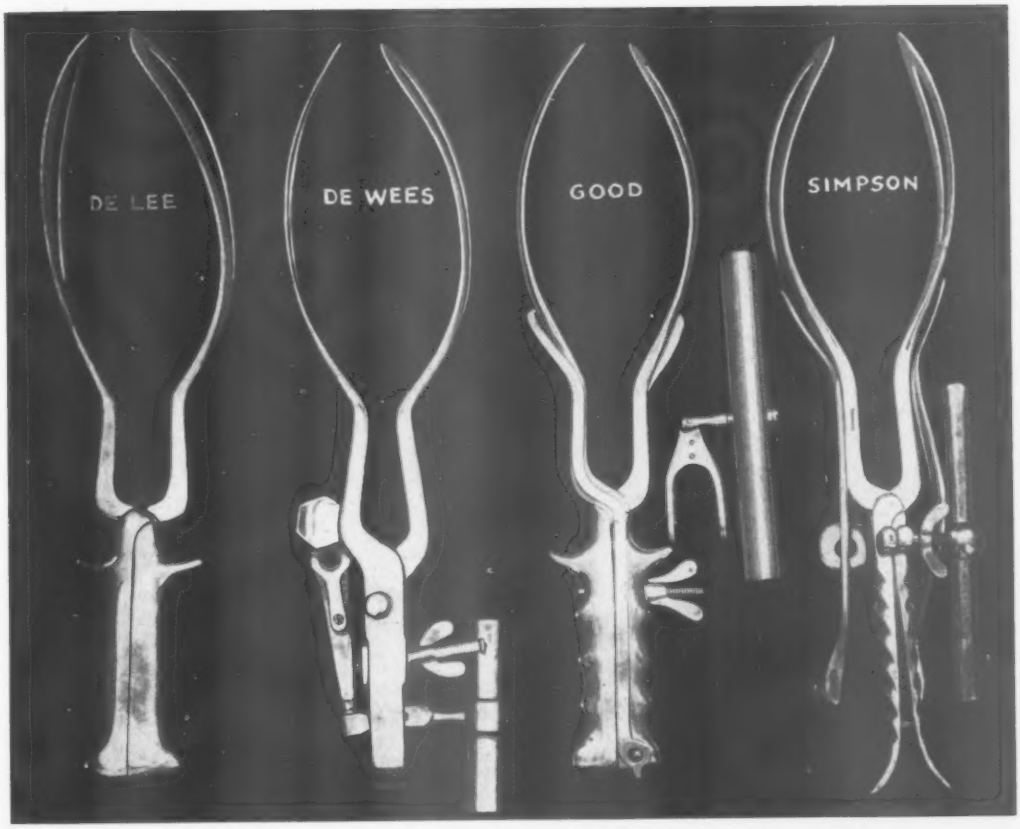

Fig. 3.—Shows Simpson Types.

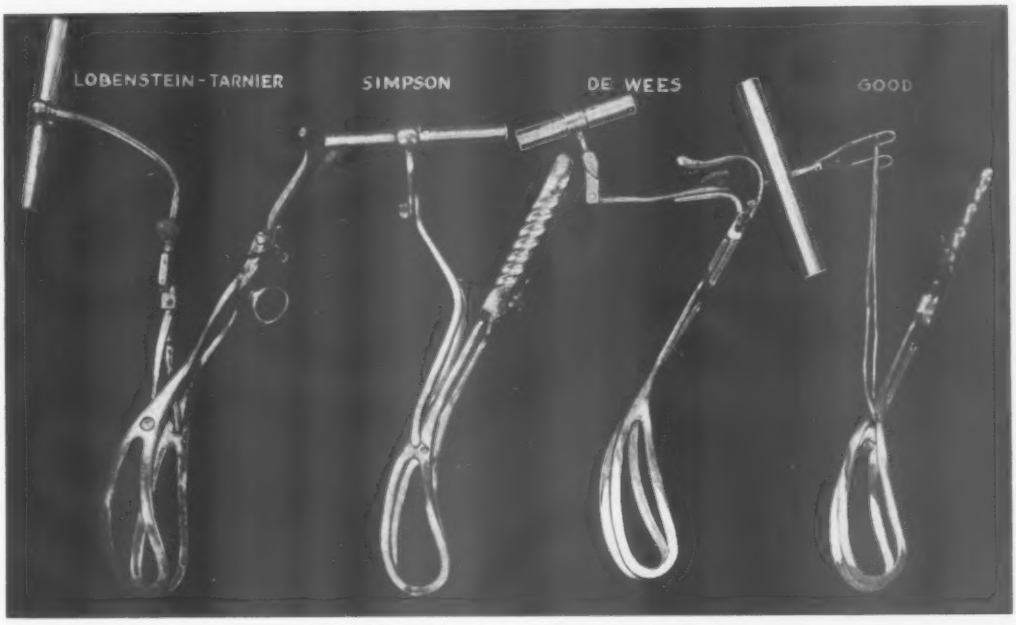

Fig. 4.—Axis-traction Attachments on Simpson Types.

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has been designed by Everett M. Hawks and Edward H. Dennen. (Fig. 5)

Several principles are included in this instrument. The advantages of application and traction tend to make the delivery easier and safer. The modified Simpson blades, with the Kielland cushion,

Fig. 5.—The Hawks—Dennen Traction Curve Forceps.

tend to fit the head without pressure points of cutting, and they do not slip, because the tips can be anchored well below the malar eminences. The exaggerated pelvic curve of the posterior lips of the blades permits extension over the perineum with the least amount of pressure on the posterior vaginal wall and sulci. The modified Piper shanks give more spring to the blades, allowing accommodation to heads of different sizes and shapes, with the least amount of compression. The backward curve of the shanks gives axis traction. (Fig. 6)

MID FORCEPS

In the mid forceps operation, more frequently than in the low, the position, as well as the shape of the head, must be considered in selecting a suitable type of instrument. The rules for anterior positions are the same in all stations of the head, with emphasis on axis traction. The DeWees' gives excellent fixed axis traction and is considered the choice by many. With the head in transverse arrest, some operators have developed their skill in the use of manual rotation, and also the gliding or wan-

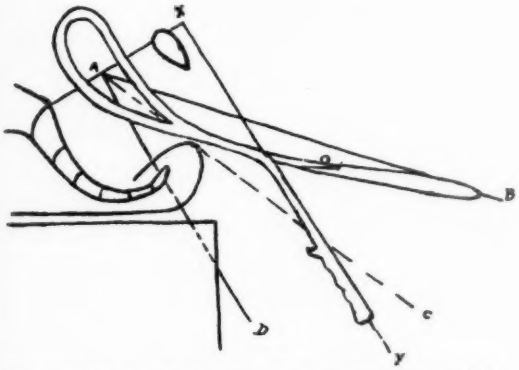

Fig. 6.—Line AB is direction of force applied to classical forceps. Line XY is the plane of handles of traction curve forceps, and is parallel to AD, the true axis traction. Line AC is the resultant of force applied in the direction of XY.

dering maneuver. However, it is not an uncommon experience to find a head which cannot be rotated manually without displacement; or one which refuses to remain anterior during the process of applying the second blade, and locking the handles. In the gliding maneuver, the anterior blade occasionally hits the brow, causing the occiput to rotate backward. This may result in a brow-mastoid application which no amount of manipulation will entirely correct. To simplify this procedure, two special types of forceps have been developed: the Kielland and the Barton. Their chief advantage is the ease with which an accurate cephalic application can be obtained. Both have the sliding lock principle which allows for adjustment on asynclitic heads. The Kielland, since it is built for traction, has a wider field of usefulness, and appears to be the choice. However, the Barton, though less effective as a tractor, often requiring another type to complete the deliv-

ery, is chosen by some because its technic of application is simpler. (Fig. 7)

In posterior positions the single accurate application, without displacement of the head, and semi axis-traction pull with the Kielland favor better results, with less manipulation than the Scanzoni, Pomeroy, and "Key in Lock" maneuvers or manual rotation. Also, the dangers of version in unfavorable cases are avoided. The Barton forceps may be used, but the advantage of traction with the Kielland in most cases makes it the choice.

This applies also the directly posterior occiput when well down in the pelvis. The upside down, direct application of the Kielland's to the sides of the head permits rotation and extraction without readjustment of the blades. The exceptions are a marked anthropoid and a marked android pelvis in which, because of limited space, it is considered necessary to deliver the posterior occiput, as such, without anterior rotation. Here a Simpson type is preferable in order to satisfy the requirements for moulding and for the need of an instrument with a good pelvic curve.

The Jacobs forceps with a swivel attachment of the shanks to solid blades may be used for rotation and traction on posterior positions without reapplication. This should be popular with those who prefer an instrument built along classical lines and applied in the classical manner.

The backward or reverse pelvic curve of the Kielland is a disadvantage in extraction through a narrow outlet with a low symphysis. Unless one is familiar with the special technique for extension with this instrument, it is thought best to remove the forceps after anterior rotation has been completed, and the head flexed and fixed with one or two tractions, substituting a suitable axis-traction forceps of the classical type with a good pelvic curve. This keeps the force in the axis of the pelvis, and lessens the danger of injury to the posterior wall and perineum. Following the proper use of the Kielland, rarely, if ever, are there any badly marked

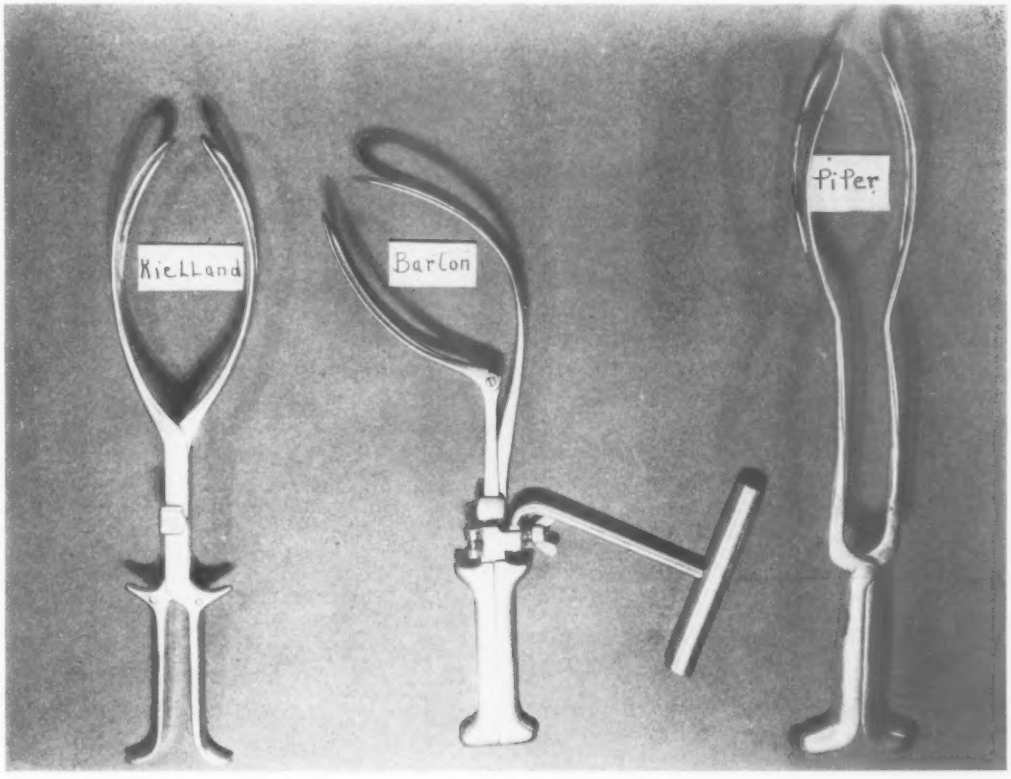

Fig. 7.—Special types of forceps: Kielland, Barton and Piper.

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faces or facial palsies. The bevelled surface or cushion on the inside of the blades eliminates the cuts and bruises, and the brow-mastoid application is avoided by using the inversion method of application. Much has been said about the dangers of the Kielland, but, as is true of any instrument, the dangers diminish as the knowledge of its proper use increases. Complicated cases have frequently been made simple by the Kielland, even after unsuccessful attempts with other types.

HIGH FORCEPS

As a rule, a high forceps should be avoided. But occasionally in well chosen cases, with version contra-indicated, it offers less risk than Caesarean section. When the head is arrested in or just below the superior straight, the same principles which apply to mid forceps are used, with one exception. This is a flat pelvis, with the head in the transverse position, and the posterior parietal bone presenting. Here, as was so well shown by Caldwell, the Barton forceps stand alone as the choice. The ease of application diminishes the amount of manipulation; the perfect pelvic curve reduces the amount of effort and minimizes the amount of injury; and the sliding lock permits adjustment as the asynclitism is corrected. If, in addition to a flat inlet, there is also a straight sacrum, the contra-indication to any forceps except the Barton is more pronounced. This principle applies regardless of the station of the head in transverse arrest. (Fig. 8)

Fig. 8.—Shows a straight sacrum, requiring Barton's for transverse arrest.

The Kielland is not chosen because when applied to this type of case its pelvic curve and axis traction cannot be utilized. It increases the angulation of the head, and, consequently, the diameter of the descending part is increased. The necessary preliminary traction in the transverse diameter to bring the head into low-mid pelvis before it can be rotated endangers the symphysis pubis and bladder, against which most of the force is directed. Hence the chief indication for the Barton's is also the main contra-indication for the Kielland's.

The Mann forceps, with flexible blades and a split universal joint, may be used to advantage. After more general use, this unique instrument may prove to be the closest approach to the long sought for universal forceps.

In face presentations, the advantages of the Kielland again make it the choice. This is particularly true when the chin is directly posterior. Here the blades may be applied upside down directly to the sides of the head, with the pelvic curve directed backward. Then rotation of the chin to anterior, followed by extraction, may be done without readjustment of the forceps.

For the after-coming head in breech extractions, the Piper forceps are the choice. The springy blades permit adjustment to heads of different sizes and shapes, with the least amount of compression. The dropped handles make it easy to obtain an application directly to the sides of the head without raising the body above the horizontal. The backward bend of the shanks gives axis traction.†

SUMMARY

1.—In a proper case for delivery with forceps, the two essential requirements are: an accurate cephalic application, and traction in the axis of the pelvis.

2.—A correct diagnosis must be made of the amount of moulding, position and station of the head, and type of pelvis.

3.—Moulded heads require a blade with a long, shallow cephalic curve as in the Simpson type. On round heads the Elliot type fits best.

4.—Instrumental axis traction diminishes the amount of effort and injury, and is desirable in any station of the head.

5.—The large variety of instruments in use shows there is no universal forceps.

6.—In the majority of anterior positions, the Simpson type of blade, with some form of axis traction is desirable.

†Much of this material with additions and alterations is reprinted from "Choice of Instrument in Delivery with Forceps", *New York State Journal of Medicine*, July 1, 1932.

7.—A special traction curve forceps combining features of several instruments, and satisfying the requirements of application and traction may be used on anterior heads.

8.—In most transverse and posterior positions, the Kielland seems to be the choice. Rotation manually, or with the Barton, the Jacobs, or the solid blades, may be used in some cases.

9.—A high transverse head, with a posterior parietal presentation in a flat pelvis, requires the Barton. This applies also to the pelvis with a straight sacrum regardless of the station of the transverse head.

10.—In face presentations, with the chin posterior, the Kielland forceps, and on after-coming heads, the Piper forceps offer advantages.

133 East 80th Street.

Explode Myth.

Exploding the myth that the American Negro is immune to stones in the urinary tract, two Richmond, Va., physicians state that "whatever natural immunity the Negro may have is certainly modified by his mode of living and the frequent occurrence of infection in the urinary tract."

Writing in the December 28 issue of *The Journal of the American Medical Association,* Austin I. Dodson, M.D., and John R. Clark, M.D., from the urological service of the Hospital Division of the Medical College of Virginia, say:

"The frequency with which we encounter calculi [stones] of the urinary tract on the wards of the Hospital Division of the Medical College of Virginia convinces us that although urolithiasis [stones in the urinary tract] may occur less frequently in the Negro than in the white race, it is by no means uncommon. Furthermore, we have observed that stones in the Negro are more frequently accompanied with infection and are far more destructive to renal tissue than those in white patients. The fact that Negroes are more reluctant to seek medical aid and depend more on home remedies than do white people certainly contributes to some extent to higher morbidity and mortality as a result of stone. The same thing doubtless contributes to the fact that calculi are less frequently found among them."

During the 10 year period from 1935 until 1946 there were 2,724 white patients and 1,800 Negro patients admitted to the urological service of the hospital, according to Drs. Dodson and Clark. Of these, 637 white patients and 121 Negro patients had stones in the urinary tract.

The doctors point out that the treatment of Negroes varies considerably from that usually considered advisable for white patients. The percentage of kidney removals is extremely high. Of 62 Negro patients with stone in the kidney, 20 had the kidney removed, while only 26 of 190 white patients were treated with such radical measures. The authors explain this by stating that "because of the difficulty in getting these patients to return for adequate follow-up treatment, more radical surgery usually is required than is necessary in the white patient."

Advances in Sulfonamide Therapy.

Three new principles in sulfonamide therapy are stressed in the scientific exhibit recently installed at the New York Academy of Medicine, by Schering Corporation of Bloomfield and Union, New Jersey. Based on recent clinical publications appearing in the medical literature, these factors are used in three different products which materially enhance the effectiveness of sulfonamides against infections.

This display has been viewed by thousands of physicians and is another scientific exhibit presented by Schering Corporation, manufacturer of endocrine, x-ray diagnostic, chemotherapeutic and pharmaceutical products.

XUM

OCCIPUT POSTERIOR AND ITS TREATMENT*

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In occiput posterior position, the presenting part is in one of the posterior quadrants of the maternal pelvis. Right occiput posterior position is more frequent than left occiput posterior position. Occiput posterior is considered a normal position by many and the majority of them deliver spontaneously and with ease. Only careful study would cause one to appreciate the normality of most occiput posterior cases and it would be hard to recognize them from the occiput anterior cases unless they were followed very thoroughly.

Calkins[1] states that "occiput posterior occurs almost as frequently as occiput anterior and that it does not produce a significant increase in either maternal morbidity or fetal mortality." In a study of cases, he concluded that the duration of the labor is dependent more upon the condition of the cervix and the character of the labor contractions rather than the posterior or the anterior position of the fetal head. Persistent occiput posterior position with arrest is considered a complication of a mechanism which is usually spontaneous and normal.

Paul Klingensmith[2] states that in a study of 4,164 deliveries, primary occiput posterior position was present in 25 per cent of the cases; that posterior rotation occurred in 2.3 per cent of all cases; that is, that one case of each 12 of the primary occiput posterior cases rotated posteriorly rather than anteriorly. We think of the fetal head, when engaging at the pelvic inlet, of adapting itself to that diameter which it best fits.

X-ray study, particularly by Thoms,[3] has shown that engagement of the fetal head as a posterior position is predisposed by a shortening of the transverse diameter of the inlet. Without any pelvic contraction and with a small fetal head, it may be a matter of chance as to whether engagement is in the anterior, oblique, or posterior position. In the anthropoid type of pelvis, not only does the head engage as a posterior position most frequently, but also internal rotation of the fetal head is prevented by the transverse contraction of the mid pelvis. When dystocia occurs with this type of pelvis, even rotation with forceps at the level of the arrested head may become difficult.

With the mechanism of labor, a fetal head, after engaging as an occiput posterior, has the possibility of then rotating anteriorly with delivery; rotating posteriorly with delivery or failing to rotate with arrest. The fetal head, when rotating anteriorly through the long arc of 135°, descends constantly unless obstruction is met. Imperfect flexion is the rule as descent occurs and the pressure of the pelvic floor tends to complete the flexion of the head. The failure of flexion at this stage substitutes a greater diameter of the fetal head than the sub-occipito-bregmatic diameter of flexion. With the head on the pelvic floor and flexion completed, the anterior rotation of 135° occurs as the occiput comes to lie directly behind the symphysis pubis. After 90° of rotation has occurred, the occiput posterior becomes in all respects an occiput anterior and from thereon its mechanism is the same.

In posterior rotation and with descent, likewise there is imperfect flexion and the rotation through the short arc of 45° occurs, causing the occiput to lie in the hollow of the sacrum at a level below the ischial spines. With further descent, and with the head in a state of deflexion, the large fontanel passes beneath the symphysis and the occiput is born by flexion and then by extension to complete the birth of the head. This is followed by restitution and untwisting of the neck. The perineum and the outlet is stretched and has to accommodate a circumference of the fetal head nearly as great as the occipito-frontal circumference, which is much larger than the suboccipito-bregmatic circumference. The outlet is subjected to this much greater stretching whenever a fetal head is delivered by forceps with the face to pubis and deep laceration can result.

Delayed rotation with imperfect flexion and molding with deflexion are factors in occiput posterior dystocia.

Anterior rotation through the long arc occurs more often and is much easier. Arrest with it is less frequent. Anterior rotation results from the resistance of the pelvic floor and from the resistance of the bony contour of the pelvis.

*Read before the annual meeting of the Medical Society of Virginia, at Virginia Beach, October 14-16, 1946.

Posterior rotation is more common in multiparous cases and relaxed perineum with lack of levator resistance is a factor in its occurrence. Poor expulsive force, deflexion of the fetal head, contraction of pelvis, relative disproportion and pelvic deformity of the sacrum and the bony outlet are frequently factors in occiput posterior arrest.

Failure of labor to progress during the second stages would cause one to suspect the possibility of arrest. Confirmation of the diagnosis can be made by careful physical and vaginal examinations. Edema of the scalp may obscure the palpation of the fontanels and sutures, and if the use of forceps is anticipated, it is sometimes necessary to feel for and identify the position of a fetal ear.

TREATMENT

When a diagnosis of persistent occiput posterior is made, the first and best treatment is conservative expectant waiting. This would include, allowing the patient to walk, positional treatment, prevention of exhaustion and the use of sedation and rest. If the first stage has not been prolonged, the period of conservative observation can be extended much longer than with a prolonged first stage of labor. Immediate interference would be indicated by either fetal or maternal distress or whenever a definite diagnosis of occiput posterior dystocia is determined. The method of interference would be to the liking of the physician. Many methods are used with satisfactory results. Internal podalic version has been used where failure of other methods has occurred.

Manual rotation, or manual rotation followed by forceps delivery, is perhaps the more popular method.

There are many descriptions of the means for manually rotating an occiput posterior position. Manual rotation alone is very effective in the multiparous case, but failure is frequent in the primipara where molding and imperfect flexion is present and the fetal head, after dislodgement and rotation, tends to return very quickly to its former position. When manual rotation is effected, immediate forceps application can be made with the head held in position by the fingers of the hand used in rotating the fetal head. Manual rotation without an anesthesia is quite painful to the patient and, with anesthesia, labor contractions are more often stopped temporarily. For this reason, manual rotation and forceps are combined to effect delivery.

The Scanzoni maneuver of forceps rotation with removal and forceps delivery is very effective in facilitating delivery. Occasionally difficulty occurs when, after removing the forceps (with rotation completed), the head tends to return to its original position. Pulling the head down after, or while rotating it, has been offered as a preventive when the head tends to turn back before the next application of forceps can be made. Mention should be made that a wide arc and sweep of the forceps handles should be used in rotating the head with forceps. This causes the head to turn in a pivotal axis, which, in turn, prevents overstretching in the pelvic canal and possible mid pelvic laceration.

After using the Scanzoni method more or less routinely for a long time and in cases where traction of a greater degree was necessary, I have rotated with either a Simpson forceps or with a Kielland forceps and reapplied an axis traction forceps for delivery. It was noticed that when one blade of the first forceps application was left in place, it would fix the position of the fetal head in an anterior position and prevent its spontaneous return to its former position. By applying the opposite blade of the axis traction forceps, then this blade could be used to fix the position of the fetal head. The remaining blade of the Simpson forceps is then removed and the second blade of the axis traction forceps applied and followed by locking and traction for delivery. From this, I began the routine use of duplicate pairs of forceps of any type or a combination of forceps of any different type, using the principle of fixing the head in position with the remaining blade of the forceps used in the rotation. In rotating the head anteriorly, slight over-rotation is advised. When removing the first blade of the initial application, the help of an assistant is necessary to hold the handle of the remaining forceps in order to fix the position of the head. Otherwise, both the head and the remaining blade will tend to turn back to its original position. When the first blade of the second pair of forceps is applied, the blade remaining is upside down. The upside down blade is removed and the second blade of the second pair of forceps replaces it and traction is then made. When applying the forceps for rotation, a good cephalic application is desirable. The second or duplicate pair of forceps when in position has been (of necessity) a pelvic application. A cephalic ad-

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justment, or so-called "sliding", can then be done to get a perfect application.

For the first application, I prefer the use of either a Simpson or a Kielland. For the duplicate, I prefer the Luikart modified Simpson forceps, or, if traction is to be more than usual, an axis traction forceps—preferably the DeWees axis traction forceps. The description of this modified Scanzoni is rather long and perhaps may appear difficult. I have found it very practical and the ease and success from its use has helped me in many a case with occiput posterior delay or arrest. It is easier to demonstrate it than to describe it.

SUMMARY

(1) The mechanism of labor normally causes occiput posterior position either to rotate 135° anteriorly and deliver, or to rotate posteriorly 45° and deliver. Anterior rotation is the easier and more normal. Deflexion delays and flexion facilitates rotation.

(2) Delayed rotation, arrest and dystocia with occiput posterior is regarded as a complication of the mechanism which is usually spontaneous and normal.

(3) The anthropoid type of pelvis, with shortening of the transverse diameters of the pelvis, predisposes to engagement as an occiput posterior. With a small fetal head and with no bony or other resistance, chance may play a part in the position in which the fetal head engages or adapts itself to the inlet.

(4) Persistent occiput position need not be dreaded because effective means of rotation and delivery can be effected. It is a distinct advantage to the mother and child to shorten the second stage of labor with delayed rotation where the first stage has been very much prolonged.

(5) A modified use of duplicate forceps, for forceps rotation and forceps delivery has been described in this paper. Its principle is much the same as in the Scanzoni method. I have found it very practical when need for interference in delayed occiput posterior position has occurred.

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DISCUSSION

DR. WAVERLY R. PAYNE, Newport News: This is a timeworn but timely subject because this condition is encountered by the general practitioner and the obstetrician alike. Its occurrence is well established; and is considered by some, as Dr. Savage has mentioned, a normal presentation and position. We recognize that the occiput posterior is a common cause of prolonged labor and may delay delivery considerably. Accurate diagnosis and accurate pelvic measurements are essential. Since many of these cases will rotate spontaneously, well chosen analgesia, watchful waiting, and the administration of intravenous fluids when necessary are all essentials to the good management of labor with occiput posterior position. All too frequently interference is inadvisedly resorted to. I agree with Dr. Savage's indications for delivery and would like to add a few suggestions.

First of all, in the arrested occiput posterior, or if for other reasons it is necessary that the patient be delivered, spinal anesthesia should be seriously considered. For many years we have used spinal anesthesia, 50 mg. of procaine hydrochloride given in either the third or fourth interspace. The anesthesia is very prompt, relaxation is complete, and the effect on the baby is nil.

Second, manual rotation is safer than forceps rotation, although I certainly should like to compliment Dr. Savage on his fine description of the method he has adopted in using duplicate forceps. I think it is a splendid idea, and it certainly overcomes one of the difficulties often encountered in attempting to do a Scanzoni operation using only one pair of forceps.

Finally, I should like to call your attention to the fact that many of these cases can be delivered rather easily in the posterior position. Dr. Lewis Douglas, of Baltimore, in a paper read before the Virginia Obstetrical and Gynecological Society some years ago, reported approximately 200 cases delivered in the posterior position. He emphasized the importance of good anesthesia and a deep episiotomy. I have found that method of management entirely satisfactory in many cases which would have been very difficult to rotate.

In conclusion, I would like to leave these thoughts with you: that in dealing with cases of occiput posterior and the usual long labor, pay attention to the patient's general condition, use analgesics advisedly, and when delivery is necessary consider low spinal anesthesia and deep episiotomy of the mesiolateral type.

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PARA-AMINOBENZOIC ACID IN THE TREATMENT OF ROCKY MOUNTAIN SPOTTED FEVER*

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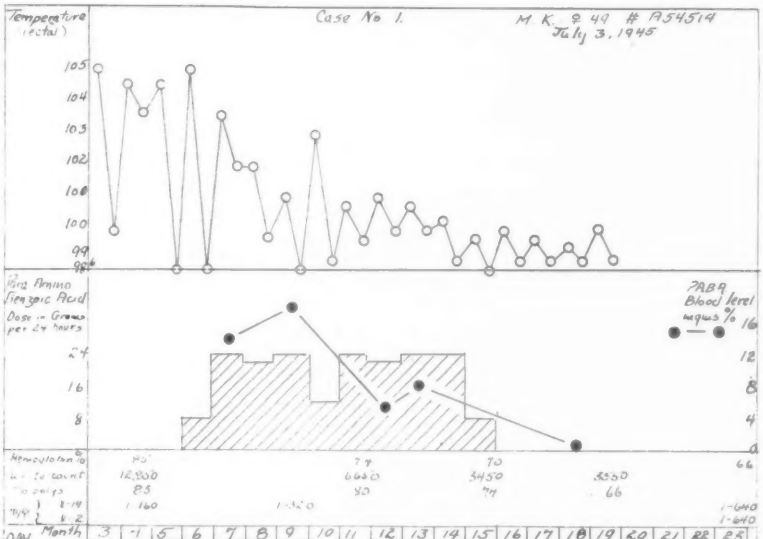
Rose, Duane, and Fischel have recently reported one case in which they used para-aminobenzoic acid in the treatment of spotted fever.[1] Their patient, a 46 year old woman, showed a satisfactory clinical response 36 hours after receiving the medication, and the authors believe the drug may have some effective therapeutic value in the treatment of this rickettsial infection. The drug was used rather extensively during the war in the treatment of louse borne typhus by the United States of America Typhus Commission at the Fever Hospital in Cairo, Egypt.[2] Other observers have shown experimentally that para-aminobenzoic acid will inhibit the growth of typhus rickettsial organisms and spotted fever rickettsiae on the yolk sac membrane of chick embryos,[3,7] and protect mice which have been given experimental typhus.[4] Anigstein and Bader found para-aminobenzoic acid to be effective therapeutically when given to guinea pigs which had been inoculated with the rickettsial organism responsible for Rocky Mountain spotted fever.[5] Our interest in the drug was prompted by an editorial in the *Journal of the American Medical Association*, which suggested para-aminobenzoic acid be tried in Rocky Mountain spotted fever.[6] We see spotted fever in increasing numbers, and it is our belief that this disease is becoming more important in this section of the country. We report on four patients treated with para-aminobenzoic acid during the summer of 1945.

In selecting the material for study, we took only those cases in which we were reasonably sure the diagnosis of spotted fever was justified. Based on the history, hospital course, and laboratory findings, four representative cases were selected for report. Other patients were treated with the drug, but are excluded from this report because we cannot clearly distinguish the diagnosis in them from murine typhus. During the summer of 1945, there was one small locality in this state which had a high morbidity as well as a high incidence of infection. Two of our patients, husband and wife, No. 3 and No. 2,



*From the Department of Medicine, Medical College of Virginia, and the Medical College of Virginia Hospital, Richmond, Va.

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came from this county. Both seemed quite ill on admission to the hospital, as did the other two cases, one of whom, No. 4, was admitted to the pediatric service of the Medical College of Virginia Hospital.

Case 1—No. A-54514—Fig. 1. A 49 year old married Negro housewife was referred to St. Philip Hospital with the chief complaint of fever and a tentative diagnosis of Rocky Mountain spotted fever. Seven days before admission, the patient complained of feeling ill without any specific complaints. Three days later a rash appeared on her arms and spread progressively to forearms, legs, trunk, back, and neck. At the same time she began to run a high fever, became disoriented, and remained so up to the time of admission. The patient lived in an area which is infested with ticks, but at the time of admission no history of tick bite could be obtained. Other members of her family had removed ticks from their bodies and from the dog. When admitted to the hospital the patient was ill, severely dehydrated, and disoriented. Her temperature was 105 degrees; pulse was 130; respiration was 30; and blood pressure was 100 systolic over 70 diastolic. There was a maculo-papular hemorrhagic eruption which was both discrete and confluent over almost the entire body with the exception of the face where it was faint. It was most pronounced on the upper arm and forearm, buttocks and thighs, and was present—but not pronounced—in the palms and soles. The anterior cervical lymph nodes were slightly enlarged, discrete, but non-tender. There was a questionable enanthem. Over the lower lobe there were a few moist inspiratory rales, but no other changes in the lungs. The cardio-vascular examination was negative except for the tachycardia. No other abnormalities were noted.

The admission diagnosis was Rocky Mountain spotted fever with secondary pneumonitis.

Admission laboratory studies disclosed a hemoglobin of 85 per cent (Sahli), a white count of 12,850 with 83 per cent polymorphonuclear leucocytes, 1 per cent eosinophiles, 1 per cent monocytes and 15 per cent lymphocytes. The urine was straw, acid, specific gravity of 1.008, with 3 plus albumin. The sediment was negative. Blood sugar and non-protein nitrogen the following morning were 105 and 28 mgms. per cent respectively. Agglutinations for typhoid "H" and "O", para-"B", and brucella were reported negative. The Felix-Weil reaction for proteus X-19 was positive 1-160. Five days later this agglutination was titered at 1-320, and the others remained negative. Wassermann was negative.

Para-aminobenzoic acid was begun on the fourth hospital day with initial dose of 8 gms., and then 2 gms. every two hours. Para-aminobenzoic acid blood levels were 14 mgms. per cent on the second day after starting the drug, and on the fourth day 18 mgms. per cent. The patient's condition was critical for the first few days of her hospitalization, with periods of great delirium and disorientation. At other times she was cooperative, and took the medication well despite the bulky nature of the drug. Three days after starting the para-aminobenzoic acid, her delirium cleared, fever lessened, and her appetite returned. After this she improved rapidly, and the medication was discontinued after ten days. She was able to give us a history of a tick bite before being taken ill. She was discharged as cured on the 21st hospital day with medication for the iron deficiency anemia.

Case 2—Fig. 2. A 60 year old married housewife was referred to the hospital with fever of four days' duration. She was a known diabetic of twenty years' duration, and had had two previous hospital admissions for regulation of her diabetes and treatment of infected callus of the right foot. Her diabetes had been regulated on protamine zinc insulin 40 units and regular insulin 20 units every morning.

The present illness began two weeks before admission with the onset of generalized malaise and anorexia. Later a slight cough and "hot" spells developed. Four days before admission she found her temperature was running between 101 and 104 degrees. Her physician gave her sulfadiazine 0.5 gm. every two hours which she took until the time of entry to the hospital. Two days before admission she removed two ticks from under her axilla, and felt so badly with headache she went to bed. On the day before admission she neglected her insulin, although she had been taking it regularly for twenty years, and on the day of admission she became confused.

Physical examination disclosed an elderly, well nourished and well developed woman who appeared acutely ill. Her temperature was 103 degrees with a pulse rate of 105 and respiration of 24. The blood pressure was 132 systolic over 82 diastolic. The physical examination was essentially negative except for a rough grade 2 systolic murmur at the apex.

The impression on admission was uncontrolled

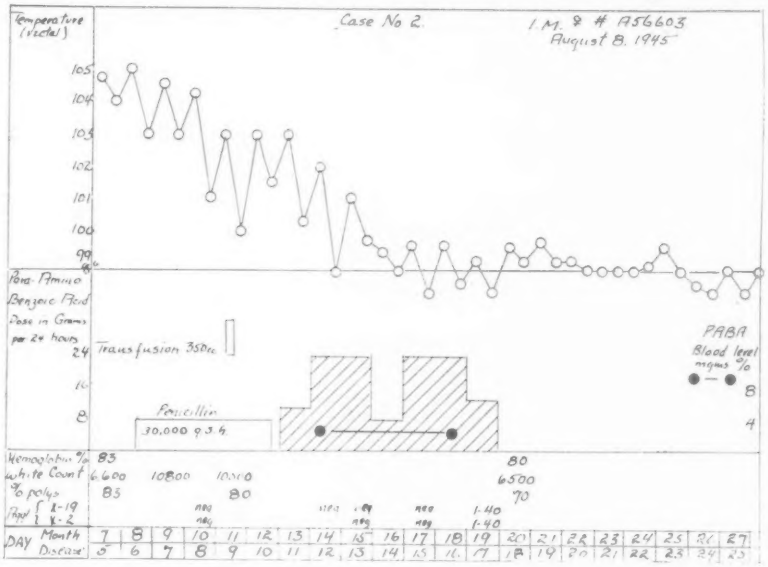
diabetes, diabetic acidosis and atypical pneumonia, after a roentgenogram of the chest showed moderately increased bronchovesicular markings in the right chest suggesting atypical pneumonia. The diagnosis of spotted fever was entertained since the woman came from a region of the state where spotted fever was known to be present in a particularly virulent form.

Laboratory work on admission showed a red cell count of 4,150,000 with 83 per cent hemoglobin; a white count of 6,600 with 83 per cent polymorphonuclear leucocytes, 16 per cent lymphocytes, and 1 per cent basophiles. The urine was cloudy, acid, specific gravity 1.030, with 2 plus albumin, and 3 plus sugar and acetone. The sediment contained occasional granular and hyaline casts. Blood sugar was 540 mgm. per cent; non-protein nitrogen was 41 mgm. per cent and carbon dioxide combining power was 52 volumes per cent. Wassermann was negative.

Initial treatment was to control the acidosis. She was given 30 units of regular insulin immediately, and in four hours 40 more units of regular insulin with 180 cc. of orange juice every two hours. In six hours the acidosis was controlled, and she was well in balance the next morning.

All blood and stool cultures were negative. A urine culture grew B. lactis aerogenes. The routine agglutinations were negative except for typhoid "O" which was positive 1-80. Because of continued elevation of temperature, penicillin was begun after all bacteriological studies had been obtained. The day after admission a few small hemorrhagic areas were first seen on the elbows and arms. In the next twenty-four hours this spread to the trunk and legs. The rash remained faint, but was definitely a rickettsial type of eruption, and was present in the palms. At this time, slight icterus was observed clinically, and an icteric index was 22 units. The spleen became palpable, firm, but nontender. The liver was not palpable.

Her diabetes remained fairly well controlled although it was difficult to get her to eat. Penicillin showed no effect either clinically or on the temperature, which persisted; so, it was discontinued. Para-aminobenzoic acid was begun on the seventh hospital day with initial dose of 3.0 gm. followed by 3.0 gm. in one-half an hour, and 2 gm. every two hours thereafter. The impression at this time was Rocky Mountain spotted fever.



During the period when the rash was most prominent, she was nervous and at times mildly confused. There was slight nausea after taking the medication, but generally she was cooperative. Two blood calcium determinations were done, and reported as 8.2 mgm. per cent and 7.2 mgm. per cent. Trousseau and Chevostek signs were not elicited.

She showed improvement following the administration of para-aminobenzoic acid and tolerated the drug fairly well. On the eleventh day of hospitali-

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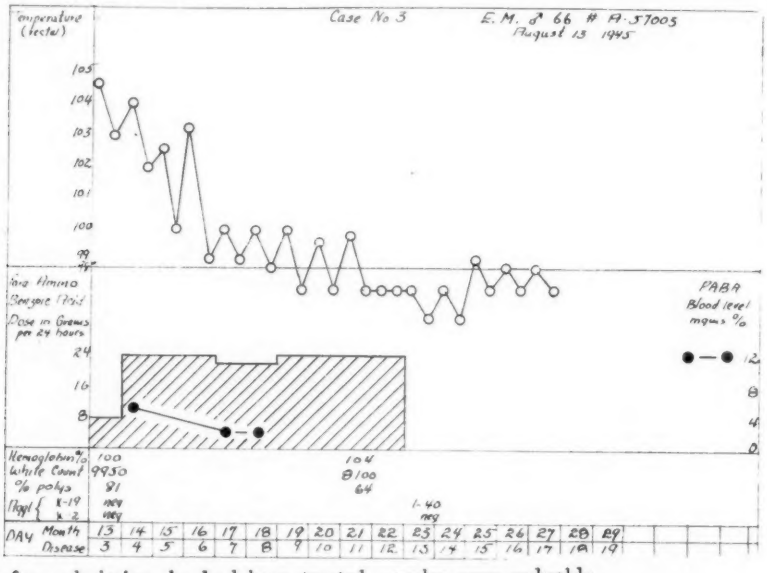
zation, the agglutinations of OX-19 and OX-2 were reported positive in a dilution of 1-40. She was discharged on the twenty-ninth hospital day, cured of her infection and with the diabetes regulated.

Case 3—Fig. 3. A 66 year old married cattleman (husband of patient No. 2) was referred to the hospital because of suspected spotted fever. The patient had been well until two days before admission when he began to feel "below par". In the next two days he became progressively weaker and had fever. There were no other symptoms. He was seen by his family physician who observed a rash and sent him to the hospital.



Six years before admission, he had been treated for a myocardial infarction. Six months before admission, he had an episode of rather severe chest pain and dyspnea, and had been advised to rest more. Two years before admission, he developed a granulomatous lesion on his penis not associated with pain or discharge. Concomitantly he developed painless swelling of the right testicle.

The patient was an obese man, mildly disoriented and emotionally disturbed with unprovoked outbursts of weeping. His temperature was 103 with a pulse rate of 105 and respiration of 20. The blood pressure was 200 systolic over 100 diastolic. There was a maculo-papular hemorrhagic eruption over the trunk and extremities and on the outer edges of the soles of the feet. In some areas the eruption faded on pressure. The eyes were tearing with puffy lids and injected conjunctiva. His pupils were miotic, but reacted to light. The chest was large and emphysematous, and moist rales were heard in both lung bases. Apex impulse was not seen or felt, but the left border was thought to be slightly outside the left mid-clavicular line. The rhythm was regular, but the heart sounds were faint, and there was a faint systolic murmer at the apex. The abdomen was obese and difficult to palpate, but one observer thought the spleen was palpable. There was a foul granulomatous discharging growth on the foreskin which prevented retraction, and the right testicle was enlarged and tender. No lymph nodes were palpable.

The admission impression was Rocky Mountain spotted fever.

The laboratory work disclosed a hemoglobin of 100 per cent with 5,500,000 red blood cells and 9,950 white blood cells with 81 per cent leucocytes, 12 per cent lymphocytes and 7 per cent monocytes. The urine was amber, acid, with a specific gravity of 1.021, 2 plus albumin, much amorphous matter, and 10-14 white blood cells in the sediment with only an occasional granular cast. Blood sugar and non-protein nitrogen were normal. Agglutinations for proteus X-19 and OX-2 were negative. Wassermann was negative.

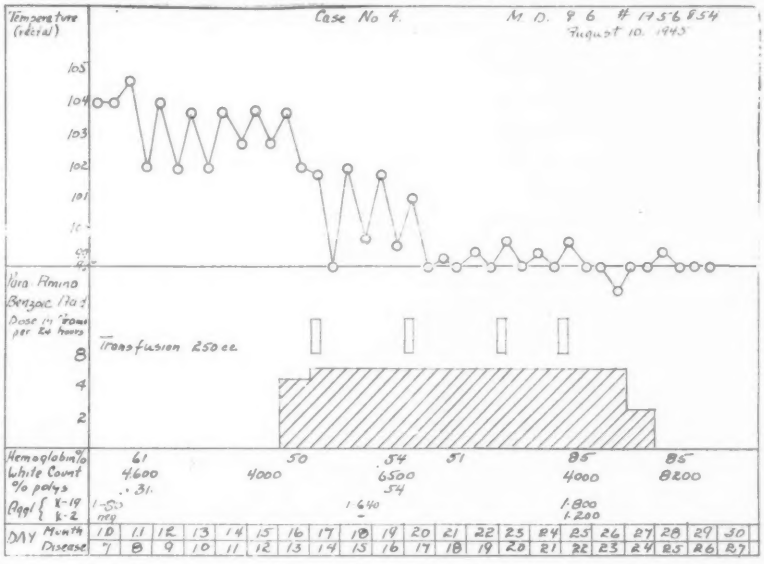
Para-aminobenzoic acid was started immediately with an initial dose of 4.0 gm. which was repeated in thirty minutes, then 2.0 gm. every two hours.

PABA blood level the following morning was 5.6 mgm. per cent. A roentgenogram of the chest showed the lungs clear and cardiothoracic ratio of 55 per cent, but there was slight enlargement of the thoracic aorta with slight pulsation and pressure on the esophagus. Blood calcium level on the second day was 8.2 mg. per cent, and five days later was 8.1 mgm. per cent. No Chevostek or Trousseau sign was elicited.

Clinically, the patient made a response soon after hospitalization with a drop in temperature by lysis. The rash began to fade and was gone in four days. Some difficulty was encountered in administering the measles, pertussis, varicella, and mumps all within the past year.

Physical examination revealed a well nourished, well developed, moderately dehydrated little girl who was irritable and complained of pain on handling her limbs. Her temperature was 104 degrees with a pulse rate of 120 and respiration of 30. The remainder of the examination was not remarkable except for pharyngeal injection, generalized abdominal tenderness, questionable spasm of the hamstring muscles and weakness of the legs.

The admission impression was poliomyelitis, and a lumbar puncture was performed which was within



para-aminobenzoic acid during the first three days when he was partially disoriented. Thereafter he improved rapidly, and was discharged on the twenty-fourth day.

Case 4—Fig. 4. A six year old Negro girl was referred to the hospital with the diagnosis of poliomyelitis.

One week before admission, she was taken suddenly ill with headache, fever, and diarrhea. There was marked anorexia, and one to three watery stools a day. Three days before admission she began to complain of pain in her legs, back, and neck. There was no nausea or vomiting. She gave no history of tick bite. Discomfort in her legs prevented her from moving about. Water was obtained from an outside well near the patient's home in the country.

Past history was non-contributory. She had had normal limits. Other laboratory work disclosed a hemoglobin of 61 per cent with 4,600,000 red blood cells; 4,600 white blood cells with 36 per cent leucocytes and 64 per cent lymphocytes. The urine was negative except for many bacteria and a few white blood cells, which were not present on subsequent examinations. A blood and stool culture and all routine agglutinations were negative, but the Felix-Weil reaction for proteus X-19 was positive in dilution of 1-80.

Treatment was entirely symptomatic, and on the fifth day, without any improvement, a maculo-papular hemorrhagic rash was present over the upper extremities and stomach. The child was very toxic. The next day the rash was present in the palms, and the X-19 agglutination was positive in dilution of 1-640. Para-aminobenzoic acid was begun with

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a 3.0 gm. initial dose, and 1.0 gm. every four hours. Therapy was supplemented with whole blood transfusions. Two days later she seemed clinically much improved. Five days later she was very much better, with a return of appetite and disappearance of the rash, and slight desquamation over the upper abdomen. The agglutination rose to 1-800 for X-19, and 1-200 for the OX-2 reaction. Para-aminobenzoic acid was given for eight days and the patient was discharged on the twentieth hospital day cured.

COMMENT

Four cases constitute too small a number from which to draw conclusions, but they serve to augment the literature which may accumulate concerning therapeutic trials of various chemotherapeutic agents. Four graphic representations of the febrile response and blood level concentrations, as well as other data concerning the hemogram and agglutinations, are presented with this report. There is a noticeable similarity between the response shown by Rose's patient and the fever graphs from our patients. Furthermore, the fever charts presented by Yeomans in his patients treated with para-aminobenzoic acid have a similarity to our graphs.[2] In typhus fever, it was felt that early administration of the drug is most advisable to obtain the greatest therapeutic advantage. In three of our patients, the para-aminobenzoic acid was not begun until late in the first week of the disease, as calculated from the history given by the patient. In one patient (No. 3), the drug was begun on the third day of the disease, and clinically this case showed the most striking response. It is our feeling that this drug modifies the severity of the infection, and hastens an early recovery from the illness. We believe that the earlier the drug can be given, the more effect it will exert. It would appear that our patients showed a response within forty-eight hours after the drug was begun. Return of appetite and absence of mental confusion were early signs, as well as a return of a feeling of well being. Unfortunately we do not have any controls on our patients. Three cases were in the older age group where the disease is more severe and carries a higher mortality. None of our patients showed any deleterious effects from the medication. We feel that this drug has a definite value in the treatment of Rocky Mountain spotted fever.

Following the plain outline by Yeomans in administering the drug, we gave an initial dose of 6-8 gm. followed by 2.0 gm. every two hours.[2] No tablets were available to us, and the powder was put up in 0.5 gm. capsules, which were large, bulky and difficult to swallow, particularly by the confused patients. It was easier to suspend the drug in water and have the patients take it that way. Sodium bicarbonate in a 1.0 gm. dose was given every three or four hours in an attempt to keep the urine alkaline. Fluids were forced orally to 2,500 cc. daily, and no cases of azotemia or anuria developed. Case No. 1, with the highest blood levels, developed a slight leucopenia, and the drug was omitted. The other cases did not show a significant drop in the white blood cell count.

At present, the most effective dose for treatment and the relation of the para-aminobenzoic acid blood level to the response are not known. Working with the rickettsiae of spotted fever in chick embryos, Hamilton concluded that the minimal effectual dose to significantly inhibit the growth of the organism, and prolong the life of chick embryo artificially infected with the rickettsiae was of the order of plus or minus 0.25 mgm. of para-aminobenzoic acid per egg. The average volume of an egg is about 50.0 cc. Assuming equal distribution of the drug, this would mean a concentration of about plus or minus 0.005 mgm. per cubic centimeter in each egg. Blood levels in three of our cases were 2.0 mgm. per cent and above, or 0.02 mgm. per cubic centimeter of whole blood. Since rickettsial organisms proliferate within the endothelial cells of the vascular bed, we may assume that they are in contact with a concentration of 0.02 mgm. per cubic centimeter of para-aminobenzoic acid. The implication is that our concentrations were about five times the minimal effectual concentration observed by Hamilton in chick embryos. The response in our patient (No. 1) with the higher blood level was in no wise different than the response in the patients with the lower blood level. Certainly more investigation should be done along this line.

SUMMARY

1. Four cases of Rocky Mountain spotted fever treated with para-aminobenzoic acid are presented. All patients recovered.

2. It is our belief that para-aminobenzoic acid exerts a definite therapeutic effect on this disease in both modifying its severity and hastening recovery.

3. No conclusions can be drawn concerning the optimal blood concentration of the drug which is apparently quite safe. Given in doses of 6-8 gm. initially and 2 gm. every few hours, one patient developed slight leucopenia.

44. Further investigation should be done as regards the treatment of Rocky Mountain spotted fever with para-aminobenzoic acid.

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UNRRA Health Division Closes.

The UNRRA Health Division, the largest international health organization the world has yet known, will wind up its activities on 31 March 1947, after more than three years of work. During this time UNRRA has made available to the health departments of 13 liberated countries the advice and assistance of its international health staff, and has also given medical and sanitation services to over a million men, women and children in the camps for displaced persons in the Middle East, Germany, Austria and Italy. To make this work possible it was necessary to recruit from 35 countries a staff totaling nearly 1,200 professional persons, including doctors, nurses, sanitary engineers, epidemiologists, nutritionists, and experts in medical supplies and hospital equipment.

For several months now, the Health Division has been handing over phases of its activity to the Interim Commission of the World Health Organization.

In order to make it possible for the Interim Commission to carry on some of UNRRA's health work pending the full establishment of the World Health Organization, UNRRA has authorized the transfer of one and one-half million dollars to the Commission.

The Eye-Bank for Sight Restoration.

Mrs. Henry Breckinridge, Director of The Eye-Bank for Sight Restoration, Inc., announces that experimentation for the improvement of vision in eyes damaged by hemorrhages as a result of injury or other causes has met with success.

Dr. Milo H. Fritz—the recipient of the Florence Ellsworth Wilson Memorial Fund Fellowship—removed a quantity of cloudy fluid from the back portion of the eye and replaced it with clear spinal fluid taken from the patient's own spine. It is too early yet to predict the ultimate result of this experiment, but the patient was able to see large objects about the ward on the morning following this operation.

So far as is known, this has been done by but one surgeon previously—Hegner in Germany in 1928. This operation is similar to that in which the vitreous humor of a donated eye is used to replace cloudy vitreous in the blind eye of a living patient, but may prove to be a more successful method.

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JUVENILE RHEUMATIC FEVER

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In 1895, Abraham Jacobi, who has been justly called the "Father of Modern Pediatrics," wrote as follows: ". . . acute articular rheumatism is frequent both in infancy and childhood. Since I have made this statement nearly thirty years ago, after observations extending over more than twenty years, a few authors have accepted and verified it; but the vast majority are of the opinion, inherited from their predecessors, that infancy and childhood are immune, or almost so. Thus—only seventeen years ago Edelfson reported to the German Congress for Internal Medicine but eleven cases of acute rheumatism under five years, none of which were younger than two. The assertion that the disease is rare under four is frequently met with. Nothing can be more erroneous . . . nor is the number of rheumatic cases limited to those exhibiting cardiac symptoms. . . . The persistent notion that rheumatism is a rare disease gives rise to an erroneous diagnosis—the ubiquitous 'dentition', 'worms', 'malaria', and 'colds'—and to false treatment. . . . pharyngitis has long been known to be connected with rheumatism, or rather to precede it. It is assumed with more than mere probability that the coccus invasion which is the cause of what we call rheumatism takes place through the pharyngeal lymph bodies, the separate follicles, and the tonsils. That is why there is no better preventive than the hygiene and treatment of the mouth and throat, from mere systematic cleanliness to resection of tonsils, and removal of adenoids."

These views were taught by this intellectual giant seventy-three years ago—even before the "Civil War". We are just now beginning to catch up with him, and to appreciate the clear-cut picture which he painted of the "rheumatic situation".

"We now know that acute rheumatism begins as a disease of school age (5-14), . . . It is estimated that this infection is responsible for 80 per cent of the deaths from heart disease under twenty years of age and 40 per cent of the total cardiac mortality itself, the principal certified cause of death in England", states Sir George Newman, in his Presidential Address, in opening the International Conference on Rheumatic Diseases, held at Bath, England, in 1928.

Although rheumatic fever in infancy is an unusual and rare finding, it is interesting to note that the literature contains a sufficient number of reports of authentic cases, so that we are warranted in saying that rheumatic fever or rheumatic carditis, occurring during the first five years of life, is no longer a medical curiosity. Our thoughts and theories regarding the life history of rheumatic fever are constantly being revised and made to fit the facts, which are gradually being revealed to us by the painstaking and laborious work of the many observers and investigators who are trying to solve the various angles of this problem. We are now paying more and more attention to the early or juvenile form of the disease, whereas, heretofore, both primary and recurrent attacks formed the basis for the figures on the age incidence. In 1920, Rolly, of Germany, in a monograph on rheumatic fever, analyzed a series of 1,450 cases, and said that he found only 4 per cent of the attacks occurring during the first ten years of life, while 40 per cent occurred during the age of ten to twenty years, and 39 per cent occurred between twenty and thirty years of age.

Our present views regarding the age incidence of first attacks of rheumatic fever differ considerably from those which were popularly held as recently as even ten to fifteen years ago. This changing picture in our conception of rheumatism is highly significant. Even today there is an utter lack in the uniformity of the criteria used by the various men in arriving at a diagnosis of acute rheumatism—they do not agree regarding the earliest signs or symptoms. Not everyone is prepared to give the same answer to the question, "What is acute rheumatism?"

Instead of assigning the peak to the second and third decades, the incidence of first attacks is now believed to be at its highest during the first decade—especially between the ages of five and twelve years. Authentic cases are now being reported during the first year of life. In most of these cases it has

been found that these unfortunate infants were being nursed by mothers who were themselves suffering from an active phase of rheumatic fever. Richdorf and Griffith reported the case of an infant, six days old, with polyarthritis associated with acute rheumatic fever in the mother. Denzer reports three cases under two years of age, all of whom had a rather fulminating and fatal course.

Smith and Sutton found that 17 per cent of their cases, at Bellevue Hospital in New York City, gave a definite history of having been infected at five years of age or younger. Roth, Lingg and Whittemore, in analyzing their series of 488 cases of juvenile rheumatism, found that 26 per cent occurred during the first five years of life, and that in 78 per cent the infection definitely occurred before the tenth year. They found the mean age at onset to be eight years. They also emphasize very strongly the fact that in one-quarter of their cases the initial affections occurred during the pre-school age. Maynard Ladd, writing in 1925 in Abt's Pediatrics, says: ". . . it is rare in infancy and it is exceedingly uncommon under four or five years of age. Infantile scorbutis may be confused with it by inexperienced physicians." Still, in an analysis of 1,027 cases of rheumatic fever, he found none under two years and only eight under three years of age. Leonard Findlay, in his excellent monograph on "The Rheumatic Infection in Childhood", states that he himself has never seen a case before the third year, and of 457 cases of rheumatic carditis, the peak occurred (100 cases) at seven years of age. This is in entire accord with the opinion of Reginald Miller, who says: ". . . it is rare under two years and uncommon under five." Sutherland, however, claims never to have seen a case under four years of age.

Poynton appears to forecast a truer picture of the actual situation regarding the age incidence of first attacks of rheumatic fever than has heretofore been believed by most of the leading students and workers in this field of medicine, when he says: ". . . The incidence of rheumatism is now generally recognized to reach its maximum during school age, but further inquiry is needed into its frequency in the first five years of life." Poynton, without difficulty, recorded numerous examples of first attacks before the fifth year. He continues: "Doubtless the frequency of the disease increases after the fifth year, but it is evident that acute rheumatism in the very young is likely to be severe, and, if not fatal, to leave behind organic heart disease . . . the first symptoms may be obscure, and those who labor under the misapprehension that the disease is very rare at this period of life may easily overlook the insidious development of primary cardiac rheumatism."

The peak in the incidence of first attacks varies only slightly in the different series of reported cases. Coombs places it at about ten years of age, while Poynton finds his to be at seven. May Wilson found the average age, in her series of 413 cases, to be 7.3 years. McClean, reporting on 122 cases, found the age incidence to be distributed as follows:

At 3 years	9 cases
4 years	9 cases
5 years	18 cases
6 years	7 cases
7 years	7 cases
8 years	20 cases
9 years	9 cases
10 years	14 cases
11 years	12 cases
12 years	5 cases

In this series the peak is reached at five and again at eight years of age. The total admissions of children under twelve years of age to the Children's Hospital of Birmingham, Alabama, during the same period, was 4,852. Rustin McIntosh and Charles Wood were able to cull only twenty-four cases of children under three years of age from the records of the past twenty-five years at the Babies Hospital (Columbia—Presbyterian Medical Center in New York City) in which they were warranted in making a diagnosis of rheumatic infection. Ninety-six per cent of their cases showed evidence of rheumatic heart disease—clinically or pathologically. Autopsies were performed in six cases. They agree with Poynton when they conclude that "The incidence of rheumatic infection in subjects under three years of age is probably greater than is generally recognized."

McClean, in discussing the "Early Manifestation of Rheumatic Infections in Young Children", emphasizes the insidious onset, and mentions the following symptoms and signs, in order of their appearance: (1) easily fatigues, (2) children are pale, (3) poor appetite, (4) weight gain is not adequate, (5) slight pains in legs, feet or joints, (6) some stiffness of limbs or neck, (7) digestive disturbances—with paroxysmal abdominal pain, (8) change

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in disposition (becoming irritable, nervous, peevish, easily frightened), (9) failure in mental concentration—begins to drop objects and have difficulty in writing, (10) slight muscle twitchings, (11) anemia. He believes that recurrent attacks may easily be precipitated by any of the following causes: (1) overwork, (2) fatigue, (3) too much excitement, (4) acute infections, (5) development of new foci of infection, (6) reinfection of old foci.

The earliest sign of any involvement of the heart itself by the rheumatic infection is, very often, the appearance of a soft systolic murmur at the apex. A short time later (several days or weeks) a mid-diastolic rumble occurs—which is considered definite evidence of involvement of the mitral valve.

In discussing the early diagnosis of rheumatic carditis, Copeman says: "Schlesinger has recently described an additional sign, based on the comparison between the sleeping pulse-rate and the normal pulse-rate in these cases, which seems to be useful, but which has not yet been reported on by independent observers."

Rothman and Leonard, in reporting four cases of cardiac failure in children under five years of age, bring out the point that there are still no specific criteria that one may use in making a diagnosis of rheumatic fever at this age. They also emphasize the fact that cardiac failure in young children presents some unusual features. They agree with Isaac Abt, who states that the earliest signs of cardiac failure in young children are most often (1) increased respiratory rate, (2) rapid engorgement of the liver.

Poynton, in an analysis of fifty-two cases of fatal rheumatic fever in children under five years of age, finds the following symptoms:

(1) definite heart disease	in 43 cases
(2) arthritis and arthritic pains	in 35 cases
(3) chorea	in 18 cases
(4) sore throats	in 10 cases
(5) nodules	in 8 cases

Poynton also states that, in reviewing 150 cases of fatal rheumatism under twelve years of age, 149 showed a definite valvular lesion at autopsy.

The close analogy that exists between the epidemiological behavior of rheumatic fever and that of tuberculosis has been mentioned, and emphasized repeatedly by many workers. After a rather complete review of the literature and a critical analysis of the subject, C. T. Burnett concludes with: ". . . rheumatic fever appears to be a communicable disease with about the same tendency to family infection as has tuberculosis. Presumably the prevention of upper respiratory tract infections will, in the future, materially reduce the incidence of rheumatic heart disease."

I agree entirely with Poynton when he says that ". . . those who have kept many records of rheumatic children must be struck by the fact that in a considerable number, definite attacks have been traced before the fifth year." In an analysis of one hundred consecutive cases of children under twelve years of age, he obtained evidence that the ". . . initial attack occurred before the fifth year in 12 per cent of the cases."

The great tendency of juvenile rheumatism to recurrence is clearly shown by Roth, Lingg and Whittemore. They also point out the fact that vulnerability is greatest during the three or four years after its onset. They therefore suggest, very strongly, that a child with this disease should be under very close observation, preferably in an institution for the first few years. In discussing the age at onset, these authors state, as their firm belief that, "Our observations of this special group leads to the assumption that acute rheumatism in children has its onset at a far earlier age than is generally implied in the literature on the subject . . . the incidence of first manifestations is highest during childhood . . . if in coming years our familiarity with the 'minor' symptoms and signs of juvenile rheumatism become greater, and if dependable diagnostic tests come to our aid, the disease may be found to have its onset among the earliest diseases of childhood."

Because this fact is apparently frequently overlooked, and because one might well emphasize once more the fact that the age incidence of first attacks of rheumatic fever is somewhat earlier than we have been in the *habit* of believing, and that it can, and that it does, occur at a much earlier age than most men have thought up to now, the following case is being reported:

Patient was a young white male child 32 months of age, acutely ill, obviously severely decompensated, who was sitting up in bed gasping for air, breathing very rapidly and having a marked respiratory grunt. The face and extremities were quite cyanotic, cold and rather clammy.

The child's history was: He was the fourth of four living children. The other three children ap-

peared to be quite sturdy and robust, despite the fact that both parents were thin, underweight, with an asthenic habitus, but appeared to be healthy enough. There was no history of any abortions, stillbirths or premature children.

The child was perfectly well until about six months before, when he had caught "cold" for the first time. He was taken to an osteopath, who treated him by various manipulations of the spine, etc., for four or five days. At the end of this time, the osteopath told the mother that the child now "had a cold throughout his entire system", and that he would have to notify the Board of Health, and that the child would need some more extensive manipulations. The mother noted that the child was beginning to grunt and to breathe very rapidly, and also that the glands in his neck were becoming quite large—something which she had never noticed before. His fever was also getting higher. She then became somewhat alarmed, and sent for a "regular" doctor. Even a cursory examination at this time revealed an acutely ill child, in marked distress and markedly cyanotic. The temperature was 105.4; the respirations were over 60 per minute and labored, and the pulse rate so rapid that it could hardly be counted. The tonsils were large, cryptic and infected, and there was a cervical lymphadenopathy. There was also evidence of an obvious broncho-pneumonia over quite a large area in both lung fields. No sign of any cardiac involvement was noted at this time. The abdomen was tympanitic, but no viscera (liver) were palpable. He was sent to the Orange Memorial Hospital at once, where the diagnosis of broncho-pneumonia was confirmed. The admitting diagnosis at this time (5/5/37) was: (1) bilateral otitis media, (2) pharyngitis, (3) broncho-pneumonia. On 5/9/37 it was noted that he was quite toxic. Hemolytic streptococci had been recovered from his throat. His temperature was 102, and his blood count was reported as follows: Hemoglobin 60 per cent; red blood cells 3,240,000; white blood cells 14,000; differential polys. 62 per cent, and lymphocytes 38 per cent. X-rays taken on admission showed a broncho-pneumonia chiefly in the lower left lobe; also a cardiac shadow that was suggestive of a congenital heart.

5/11/37.—Blood count had changed to: Hemoglobin 55 per cent; red blood cells 2,800,000; white blood cells 17,100; polys. 42 per cent, and lymphocytes 58 per cent. Sedimentation rate was 14 mm. in 30 minutes, and 35 mm. in 1 hour. Urine was negative. Child appeared to have gotten over the acute phase of his illness, but was listless and apathetic.

5/14/37.—Temperature was normal. Pulse, however, was somewhat irregular and quite high. Patient was again "toxic". X-rays suggest the possibility of a miliary tuberculosis. Mantoux was negative in all dilutions.

5/17/37.—Transfusion of 120 cc. of whole blood was given, by direct method, with a good reaction.

5/18/37.—Blood count now showed some improvement, as follows: Hemoglobin 68 per cent; red blood cells 3,780,000; white blood cells 9,100; differential polys. 54 per cent; lymphocytes 44 per cent; monocytes 2 per cent.

5/20/37.—Temperature still normal. Pulse still somewhat irregular (type of irregularity is not noted on the chart). X-rays still suggest the presence of a miliary tuberculosis. Broncho-pneumonia clearing quite nicely.

5/22/37.—Stomach washings negative for tuberculosis.

5/25/37.—Patient was discharged from the hospital with a final diagnosis of (1) nasopharyngitis, (2) broncho-pneumonia.

It was suggested that the child be given a high caloric, high vitamin diet. The child did fairly well at home for about a month, when he became acutely ill again. He now presented a different picture than he did at the beginning of his "first" illness, three or four weeks before. He had not voided for the preceding 24 hours. His respirations were labored and increased in frequency—about 50 per minute. He had now only the suggestion of a grunt; he was pale and not cyanotic as previously. His face appeared to be somewhat bloated. There was some pitting edema of both his lower extremities up to the middle of his thighs. His abdomen was tympanitic, but this time his liver filled most of his abdominal cavity, extending almost to his symphysis. There was no impairment to resonance over either lung field, but many moist and some bubbling rales could easily be heard over both lungs. The area of cardiac dullness was markedly enlarged. A loud double murmur was heard at the apex, and to a somewhat lesser extent over the entire precordium. This could be heard very distinctly in the left axilla and under the left scapula. No friction rub could be heard. There was a sug-

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gestion of a diastolic murmur over the aortic area. The neck vessels pulsated violently. A very poor prognosis was given, but immediate hospitalization was advised.

He was admitted to the Homeopathic Hospital on June 2, 1937, where he was treated quite vigorously with limited fluid intake—to 500 cc. in 24 hours, ammonium chloride, 60 grains daily, intravenous salyrgan, codeine phosphate every three or four hours, and oxygen tent. He began to void almost at once. The liver receded, the edema of the extremities was markedly reduced and his breathing was much easier. This regime was discontinued in 48 hours, and on June 4, 1937, he was given digalen—2 cc. by hypodermic injection, three times daily for three days. He was also given 1 cc. of salyrgan intravenously. He reacted splendidly, and on June 9, 1937, the liver was only about one finger's breadth below the costal margin, the peripheral edema had all disappeared and his chest was clear of any moisture. He was quite lively, no longer listless, and very hungry. He continued to convalesce and improve very nicely, and walked out of the hospital on June 19, 1937. The area of cardiac dullness was still about 75 per cent of the chest diameter. Regarding the laboratory findings, it is noteworthy that the urine was always negative, that the sedimentation rate was never any higher than 11 millimeters in one hour. His hemoglobin varied between 59 and 62 per cent and he had about three and one-half million red blood cells per cubic millimeter. His mother was advised to take him to the shore for the summer, to limit his physical exertion, give him frequent sun baths, and to give him a high caloric, high vitamin, high iron diet. The mother carried out these instructions, and he did very well. On his return, in the Fall, examination revealed the fact that his cardiovascular system was compensating very well. His heart was still quite large. A loud double murmur was easily heard at the apex, transmitted to the entire precordium, to the left axilla and posteriorly under the left scapula.

On October 2, 1937, he caught "cold" again, and was readmitted to the Homeopathic Hospital on October 5th, with a diagnosis of (1) rheumatic pancarditis with decompensation, (2) broncho-pneumonia. He was acutely ill. His face was bloated, and there was pitting edema of his lower extremities up to the middle of his calves. His liver was at the level of his umbilicus. The area of cardiac dullness was still as large as before (75-80 per cent of the chest diameter). There was some impairment to resonance over the right middle lobe, and both lung fields were filled with many moist bubbling rales. There was no evidence of any free fluid in either pleural sac. A harsh to and fro murmur was heard at the apex. He had not voided for the preceding twenty-four hours. Fifty cc. of 25 per cent glucose and 1 cc. of salyrgan were given intravenously. Ammonium chloride, codeine phosphate, and phenobarbital were also given. He did not void as freely as he should have after this treatment. A transfusion of 60 cc. whole blood was given on October 8, 1937. He reacted very poorly, continued downhill quite rapidly, and died October 9, 1937—just one week after the onset of his latest recurrence.

Three days before he died, on October 6, 1937, the urine was reported as essentially negative, white blood cells as 15 thousand per cubic millimeter with 72 per cent polys., and 28 per cent lymphocytes; the hemoglobin was 52 per cent, and there were 3,400,000 red blood cells per cubic millimeter. The sedimentation rate had now gone up to 30 millimeters in one hour.

An autopsy was performed by Dr. Edward Fendrick. The essential postmortem findings were as follows:

Gross.—The body was that of a well nourished and well developed white boy. The veins of the neck and upper chest were congested. The abdomen was full. The lower extremities showed slight pitting edema.

Chest.—Both pleural cavities contained a few cc. of straw-colored clear fluid. Both lungs were collapsed. No adhesions were noted. Involving the lower parts of the upper apex of the right lung, the middle lobe, and the upper part of the lower lobe, there was a demarcated patchy area which was dark brown and airless. The left lung was crepitant throughout. On squeezing it a frothy, bloody fluid exuded.

Heart.—The pericardial sac contained excess fluid. The organ was markedly increased in size and weighed 240 grams. The left ventricle showed a wall which was much thicker than normal, and the cavity was enlarged. The heart muscle was deep red in color and tough in consistency. The free margin of the mitral valve showed slight thickening. The endocardium of the left auricle was somewhat cor-

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rugated. Elsewhere the endocardium was free and clear. The right auricle and ventricle were dilated. The pulmonary and systemic aortae were free and clear.

Cause of Death.—Chronic rheumatic myocarditis with secondary broncho-pneumonia.

Microscopical.—Lungs.—The tissue about the small bronchi showed a round cell infiltration. The walls of the alveoli were thickened and fibrous, and the alveoli contained numerous desquamated cells of the "heart failure" type. Occasional alveoli contained granulocytes.

Heart.—Within the interstitial tissue of the heart muscle fibres were inflammatory lesions, consisting of round and plasma cells, with occasional giant cells—characteristic of Aschoff's bodies. Many of the lesions were seen in relation to the small branches of the coronaries.

Final Diagnosis:

(1) Congestion of kidneys
(2) Congestion and chronic interstitial pneumonitis
(3) Broncho-pneumonia
(4) Chronic interstitial rheumatic myocarditis
(5) Congestion and hyperplasia of spleen
(6) Congestion and central necrosis of liver

The most interesting feature of the pathologist's report is the "*chronic*" interstitial rheumatic myocarditis. The pathological picture of the lung tissue was very similar to that found in so-called "rheumatic pneumonia". Because of the chronic nature of the microscopic appearance of the heart muscle, I believe that we are warranted in assuming that the rheumatic infection was not of recent origin in this patient. He may very probably have had the infection for six to twelve months, or longer, before death occurred, so that the age at onset, in this patient, may very easily be put at one and a half to two years.

Birth History: Pregnancy was full term, and the baby weighed seven pounds and ten ounces at birth. Labor was not difficult, nor was it prolonged. Delivery was spontaneous.

Past History: Feeding history was, apparently, perfectly normal, rational and adequate. Baby was not breast fed. The diet was evidently well balanced throughout his entire life—especially with regard to the accessory food factors, etc. He had had none of the "diseases of childhood" previous to the onset of the present illness.

Family History: There was no known history of rheumatic fever in either parent or in any of the other three children.

Social History: It is significant that this was a "depression baby"—or, according to the newer terminology, a "recession baby". The family had been in moderately comfortable circumstances until about a year before the birth of this baby. They lived in a nice comfortable one-family house, and then quite suddenly—due to a number of financial reverses, they were forced to move to a cold "railroad flat" of three rooms. The mother, during this pregnancy, had to deny herself all but the bare necessities so far as food and clothing were concerned. After the baby's birth, he was, of course, brought up in this cold, damp house. Despite all this, he appeared quite strong, and even robust, up to the onset of the present illness, and, according to the history given by the mother, he never showed any of the usual symptoms often associated with the early manifestations of juvenile rheumatism—such as tonsillitis, sore throats, getting "cold" easily, pains in the limbs, easy fatigability, listlessness, paleness, etc.

Mother had frequent "squabbles" and "scenes" with her husband. When the child was six months of age the parents were separated, and did not become reconciled until about a year later. This child was accepted, but was not entirely welcomed or wanted. The home atmosphere was rather turbulent and not a happy one. The tension in the home was quite marked. All this wrangling, etc., started, coincidentally, at about the same time that the mother became pregnant with this child.

Comment: It is not only interesting but instructive, to speculate about the various elements that contributed to the development of rheumatic fever in this patient. An answer to the question, "What were the pre-disposing factors that allowed this infant to develop rheumatic heart disease?", would certainly be most enlightening, and might shed a ray of light on a relatively dark and unexplored corner of preventive medicine. It is refreshing and healthy to stop, every now and then, to take an inventory of, and to carefully scrutinize all of the "old" and the more recently acquired facts about any disease—to add and subtract all of these facts, and to see just what our sum total of knowledge really is, and, using this as a guide, to carry on from there. Pope once said, "Be not the first by

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whom the new are tried, nor yet the last to lay the old aside", which is certainly a very safe rule to follow, but certainly we should have an open mind and be receptive to "the new".

The Rt. Hon. Lord Dawson of Penn, in a talk entitled "Environmental Factors in Rheumatic Disease", says, ". . . It is environment which holds the larger responsibility—defective methods of housing and domestic living; lack of light and air and opportunities for recreation. . . . We are only gradually learning what the value of recreation is, and how it should be applied and used." "I am convinced", says Harold Bachamann, "that environment is an important factor; whether it be poverty, dampness, poor nutrition or lowered resistance." Further along, he says, "It is infection which excites the heart failure, so distressing in childhood, and not exertion." C. Wilfred Vining, in writing about the "Pre-Rheumatic Child", states that "Rheumatism of childhood is primarily a disease based upon a nutritional disturbance brought about by a prolonged dietetic deficiency either in vitamin B, or a deficiency in protein in conjunction with a relative excess of carbohydrate or possibly to both these factors . . . prevention lies first and foremost in the provision of a well-balanced diet from infancy onward."

A. Dingwell Fordyce, in discussing the "Predisposing Factors in Rheumatic Infection in Childhood" states ". . . an important predisposing factor toward rheumatic infection in childhood is *instability of the nervous system*" (italics mine). When our patient made his debut into this world, the stage was all set; he was handicapped right from the start (and even for a year before he was born) —poverty, dampness, poor nutrition and a more or less uncertain food supply. Careful scrutiny of the histories of any series of cases of rheumatic fever will undoubtedly bear out the contentions of Jacobi, Poynton, Roth and other leading investigators that the earliest manifestations of rheumatic fever can very often be found before the children are five years of age.

In addition to all of those factors, I believe that we must also take cognizance of the work of Homer Swift and his colleagues, at the Rockefeller Institute, who believe that rheumatic fever is a manifestation of hypersensitiveness to streptococci, resulting from repeated low grade infections in the body.

SUMMARY

A case is reported of rheumatic fever in an infant, together with autopsy findings. A number of predisposing factors that may probably have played an important part of this patient's fatal rheumatic infection are discussed. The point is also brought out that first attacks of juvenile rheumatic fever occur at a much earlier age, and with greater frequency than we have been in the *habit* of believing.

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Schering Award Competition.

"The Clinical Use of Androgens in the Female" has been selected as the subject for the 1947 "Schering Award" competition among medical students in the United States and Canada, according to Dr. John N. McDonnell, Director of Domestic Sales and Promotion for Schering Corporation, Bloomfield, N. J. As in previous years, cash prizes of $500.00, $300.00 and $200.00 will be given for the best manuscripts received on this subject. Three judges prominent in endocrinology will select the winning entries. Dr. Norman L. Heminway, head of the Schering Medical Service Department, is chairman of the Schering Award Committee and in charge of the competition.

The "Schering Awards" are offered annually in competition to stimulate the acquisition of further knowledge of endocrinology by medical students, as a contribution to Medicine by Schering. Many students from almost a hundred medical colleges will submit their manuscripts for this year's Schering Award Contest which closes July 31, 1947.

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DISSIMULATION IN SCHIZOPHRENIC PSYCHOSES*

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As stated in Proverbs[1] the way of the fool is right in his own eyes; fools despise wisdom and instruction,[2] and a fool has no delight in understanding.[3] However, as Proverbs further state: even a fool when he holdeth his peace is considered wise, and he that shutteth his lips is esteemed a man of understanding.[4] The fools are accordingly advised to keep their mouths shut, especially as far as their ideas which are considered foolish by the society are concerned; it is an advice for the fool to dissimulate, to hide his foolish ideas. Psychotherapy in the form of dissimulation is accordingly very old and it has been used as a method of treatment of psychoses repeatedly. Both the Tikkun Pgam of the old Cabbalists and the religious exercises of Ignatius Loyola appear to be forms of mental treatment by dissimulation. A survey of older ideas on this subject is given in Burton's Anatomy of Melancholy.[5] Nowadays it was the Vienna school of Stransky and Kogerer[6] which has developed a new method of treatment of schizophrenia by dissimulation.

The following case reports shall illustrate the spontaneous tendency for dissimulation as observed in both abortive and developed cases of schizophrenic psychoses.

Case 1.—It was a 55-year old white woman of pyknic constitution with a face resembling a full moon and with rosacea on both cheeks. She was lying quietly in bed and her full moon face did not show any signs of emotion when the examiner appeared. Neither did she change her comfortable position in bed nor did her face exhibit any emotional display most of the time during the examination. Nevertheless, there was a great deal of frozen suspicion in her facial expression, and an unmistakable tendency to mask this by a matter of fact expression. (Why here?) "They did not explain it to me. (This is a hospital for mental diseases.) She appears trying to turn her face towards the examiner. With stiff astonishment she says: "Is it? I see . . . I guess it is . . ." (Why here?) "I do not know. I guess I'll get well" (?) "a good while ago I was in the Lakeland Hospital for one year and four months. They confined me 'here." "Through confinement." This is incoherent. (Have you been insane?) "Irish people are not crazy!" After a while, however: "Do you think I'll get well and go home?" She denies having called her neighbors bad names: "I am a Catholic lady!" (They say you did.) "Do they? Is not that awful?!" She admits having heard God's voice. According to the commitment papers, she had ideas of persecution and kept on aggravating her neighbors 2 years ago, but she promised to be good. This promise she was able to keep until 2 weeks before her commitment to the hospital. She then accused the neighbors of calling her bad names and threatened to kill them with a club.

Impression: This is a psychosis with auditory hallucinations and both persecutory and religious delusions. The diagnosis of a paranoid condition was made, and this examiner believed it to be a case of schizophrenia, paranoid type, which was modified by the patient's ability to dissimulate her psychotic symptoms for many years. She was trying to be good.

The mental activity of the complexes in a schizophrenic is so forceful that, as a rule, these complexes use to break the thin layer of reality consciousness covering them and then the psychosis becomes manifest in spite of all attempts to dissimulate it, as shown in the following case:

Case 2.—L. G. B., 63 years old, single, farmer, Protestant. This is his ninth admission to this hospital, and it appears to be the tenth attack of the psychosis. He had an attack of violent excitement before his commitment to the hospital; however, when in the hospital he quieted down, appeared depressed and worried and cooperated very well. He was very well oriented. On the same day he became extremely noisy, restless, disturbed and resistive, and he had to be put in restraint. During the physical examination performed on the next day the patient was very restless, appeared considerably confused, and he kept on gesticulating in a queer way with both his hands and striking the wall with his fists, apparently in order to emphasize in this

*From the Longview State Hospital, Cincinnati, Ohio.

way his utterings. These, however, were greatly confused, fragmentary and without any connection. This inner restlessness, excitement and confusion continued for 3 days and afterwards he was quiet. During the mental examination the patient was quiet and cooperated very well. No mannerisms or catatonic attitudes were noted. His face expressed a great deal of embarrassment and a lot of guilt. There were dark rings around his eyes and from time to time a marked grimacing could be noted. His face was always directed towards the examiner. He stated that he never married in his life nor did he have any sexual experiences whatsoever; that there is nothing wrong with his mind. (Why here?) "I guess I must have been afraid of something." He never was playing with himself; he had a phymosis and at the age of 25 he was circumcised. This phymosis has apparently determined the psychogenic superstructure of his psychosis. He states: "I never want something like that (masturbation). I never wanted to get something; I do not want anybody to blame something on me. Before the operation it was not possible. When I was a small boy I would hear people say that he who plays with himself comes always to the 'bug' house" . . . I was always very careful . . . I was afraid . . . I was afraid that if I would get arrested I would not be able to explain myself . . . I would rather wait and hold the water when it was too bad then to have an officer come and find me when I was letting water . . . If they would find a man doing something like that in front of a lady that would be a disgrace forever. When I was working in a place where a lady was working I would not want to go into that place where the lady was working. I did not want to ask her anything, but I did not want to use it at that time. I would not feel like using it at that time; my mind was somewhere else. I wanted to be perfect if I could; and I knew I could if I would not say anything . . . I would rather go to a place where I could get one . . . I went down to the basement of that place . . . I knew there was one there. One time I was reported to the woman in charge of the toilet . . . I would go miles off my road to get a toilet". (How did you happen to come to the bug house?) "Before the first admission I have been working in the station; I was a fireman in the custom house. That was the first place where I got it. It has affected my eyes . . . When I was in school I always went to my home place to use the toilet. You could get a thrashing or something like that if you were reported that you were standing around in the toilet. I never wanted anyone and I never wanted to stand. I always looked in a different direction. I never wanted that one should know that I would go in a place like that . . . My eyes always jerk since that time. I felt miserable from it . . . I felt awfully miserable. The eyes could make you believe that you are losing your sight . . . that you are losing your head . . . your brain . . . That was when I was working in the custom house during Cleveland's second term. I knew everything that was going on and I was trying to save myself but I could not do it. I felt bad all the time but I did not tell it to anybody. I was afraid they would say: 'You have to go to the bug house' . . . My brother saw that . . . that something was going on with me, and he said I ought to have a treatment; he sent me to the state hospital. It must have been going on for a year before I came to the hospital. I would not complain to anybody. The only thing: I would not answer. I never would laugh and would not talk. I had only a few words to say, would say 'yes' or 'no'. I saw it was funny but I could not do anything against it. I would try to do the best . . . When you are in a condition like that you always want to have friends. When you have friends . . . when they say a few words to you—that makes you feel different! Money would be of no account when you have that feeling!" (What happened before the last admission?) "I could not sit still on account of my piles. I would pace around in my room. I did not want to do anything wrong when I came here. I did not want to hurt anybody, did I?" Tears appeared in his eyes. "When I came here I was absent-minded and I lost my memory." In accordance with Bleuler's classification, the examiner believed it to be a case of abortive schizophrenia.

This case reveals the mental tortures a schizophrenic patient undergoes when he tries to adapt himself to the reality by dissimulation. Nevertheless, by dissimulating his psychotic symptoms, by trying to adapt himself to the reality, this patient, like many other similar cases seen by me, was able to stay out of the "bug house" most of his life, and no appreciable amount of schizophrenic deteriora-

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tion could be noted in this case upon his ninth admission to the hospital. Dissimulation accordingly appears to be a purposeful phenomenon, especially in schizophrenic psychoses, and should be encouraged as a method of psychotherapy. However, no attempt should be made to encourage the spontaneous dissimulation which used to be observed in cases of manic-depressive psychosis, depressive state (melancholia), and frequently ends in a suicide of the patient.

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Penicillin Therapy in Scarlet Fever.

Writing in the March 8 issue of *The Journal of the American Medical Association*, Harold L. Hirsh, M.D.; Georgine Rotman-Kavka, M.D.; Harry F. Dowling, M.D.; and Lewis K. Sweet, M.D., who are from the George Washington University School of Medicine, Washington, D. C., report that they used penicillin in the treatment of 86 patients with scarlet fever and found that:

Penicillin brought a prompt fall in temperature, decreased toxicity and practically eliminated the danger of patients carrying the disease and infecting others.

Penicillin was more effective than scarlet fever antitoxin in the prevention of complications.

Throat cultures were free of scarlet fever germs within 48 hours after penicillin treatment was started.

Use of penicillin eliminated the frequent occurrence of serum sickness following the use of antitoxin.

In another *Journal* article, Drs. Archibald L. Hoyne and Rowine Hayes Brown, who are from the Municipal Contagious Disease Hospital of the Chicago Health Department, relate how they used penicillin exclusively on 116 scarlet fever patients during the last 14 months. They found that:

Penicillin is equally as good a therapeutic agent for scarlet fever as convalescent scarlet fever serum.

Penicillin is superior to sulfonamide drugs as a therapeutic measure for scarlet fever.

The big advantage which the penicillin-treated patients possessed was that fewer complications followed its use than occurred with other forms of treatment.

Winthrop Opens New "Dustless" Building.

A new four-story brick and glass, windowless, germ and dust-proof laboratory plant designed to be run under constant scientific control for the preparation of injectible medicines in ampuls has been opened at Rensselaer, N. Y., by the Winthrop Chemical Company, Inc. Engineers of the Austin Company, who built it starting in May 1945, characterized the completed job as a "scientific utopia" and "one of the most complex and intricate examples of controlled-conditions buildings to be seen anywhere".

Most unusual feature is the unique system of dedusting passageways in the basement. Before entering the main building where the medicines are made, all employees and visitors must walk through one of two narrow passages lined with double dedusting blowing and suction units designed to remove lint and dust from their clothing.

The preparations are made in 35 individual, isolated, germ-proofed, air-conditioned and controlled compartment laboratory workrooms. Every appropriate scientific development has been adopted to provide as nearly perfect conditions as possible for the production of medicines in injectible form. The building creates its own weather through modern heating and air-conditioning systems.

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DO BONY SPURS CAUSE PAIN?

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This is an important question. Medical literature seems to be arrayed on the affirmative side. We believe the negative side is nearer the truth, and the present attitude of the profession is an impediment to progress. If this discussion adds to the enlightenment of the subject, it will be a forward step.

If the bony spur does not cause pain in osteoarthritis, what is the origin of the pain? We believe that it originates in an inflamed muscle, and unless there is a myositis present, there is no pain.

The disease may progress for some time without pain, but as soon as the muscles are involved, pain becomes the dominant symptom. Therefore, in a case of osteoarthritis with pain, a thorough palpation of the muscles should be made to find the seat of the inflammation; and when this is found, proper physical therapy should be applied.

It is customary at present, if a patient presents himself with back pain and the x-ray shows one or more spurs on the spine, to prescribe a brace or surgical corset and turn him loose with a diagnosis of osteoarthritis. This results in great mental trauma and leaves the pathology untouched and the pain only modified. If the back muscles were carefully palpated in these cases, a chronic myositis would be found, which would yield to proper physical treatment.

In painful and swollen knees showing spurs on x-ray examination, the spurs are quickly incriminated, whereas the real culprit is the overlying muscular inflammation.

It is the recurrent attacks of myositis with ever increasing exudates and induration that cause the pain in this disease, the bone playing a silent role until late in the disease when bone hypertrophy has become dominant. It is only then that the muscles take a subsidiary part.

To exemplify: A man, age 72, suffered with his left shoulder, left leg, and especially his back. He was quite lame, walked with a cane, and wore a brace over the lumbar spine. He had been seen by several physicians. The x-ray showed one or more spurs on the spine; a diagnosis of osteoarthritis was made, and a brace over the lumbar spine was prescribed. On examination, a chronic myositis was found involving the left deltoid and the muscles around the left pelvis and the upper part of left thigh, as well as the right lumbar region. After four weeks of physical therapy, he was free from pain and had discarded his brace and cane. At this time he was walking two to three miles daily.

A woman in the sixth decade of life had been suffering with pain in the lower back over a long period. She was examined at a large clinic, the x-ray showing spurs on the spine; the diagnosis of osteoarthritis was made and a surgical corset prescribed. In this case, a chronic myositis of the lumbar muscles was found. This patient was entirely relieved of pain after four weeks of physical treatment.

A woman, age 80, with painful and swollen knees, said her physician had reported a spur as the cause of the trouble and advised rest for the knee. This case showed a myositis of the muscles around the knee, which myositis yielded to massage in three weeks.

From the practical standpoint, these were cases of myositis and should have been so diagnosed. The spurs were not causing trouble and probably never would. If proper search had been made, the muscles—not the insignificant spurs—would have held the center of the stage. The pathology which is reversible is in the muscle, and active physical therapy is indicated. Immobilization in these cases is harmful.

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PUBLIC HEALTH

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The report of the Bureau of Communicable Diseases of the State Department of Health for February, 1947, as compared with the same month in 1946, and for the period of January through February, 1947, compared with the same period in 1946, follows:

	Feb. 1947	Feb. 1946	Jan.-Feb. 1947	Jan.-Feb. 1946
Typhoid and Paratyphoid	7	4	10	11
Diarrhea and Dysentery	150	116	301	221
Measles	893	953	1,389	1,493
Scarlet Fever	143	262	306	528
Diphtheria	27	40	64	103
Poliomyelitis	5	0	9	1
Meningitis	12	24	22	60
Undulant Fever	2	5	2	7
Rocky Mountain Spotted Fever	1	0	1	0
Tularemia	8	4	24	21

SMALLPOX VACCINATION

Many inquiries reach the State and local health departments relative to approved technique in smallpox vaccination. In response to these questions the following recommendations are presented with the additional assurance of essential approval by the American Public Health Association and of the United States Public Health Service:

RECOMMENDATIONS

1. Vaccinate at the age of eight to ten months, either alone or in combination with the second diphtheria and tetanus injections. At this age reaction or complication seldom occur and the vaccination scar is minimal.
2. The approved site of vaccination is that skin area immediately over the deltoid insertion and usually that of the left arm. Clinical difficulties are more frequently encountered when other sites are chosen.
3. Smallpox vaccine must be stored and transported in the frozen state. Efficient vaccination is only possible under the above conditions, removing it from refrigeration a short time before use. The biological should not be used beyond its expiratory date.
4. Acetone is preferred for antiseptic application to the skin area to be vaccinated. Alcohol, iodine, phenol and other antiseptics will frequently destroy the vaccine virus.
5. The multiple pressure method of vaccination is preferred to all other. With proper technique the possibilities of reactions and complications are minimal and the cosmetic result more satisfactory.
6. Loose fitting clothing of light smooth material is recommended during the active period of vaccination. Constriction and irritation are likely to lead to clinical difficulties.
7. The application of shields and dressings to the vaccinated area is condemned, as their use predisposes to severe reactions and to complications. Exception is made in cases with profuse drainage, in which instances dressings loosely applied with adhesive strips parallel to the long axis of the arm may be used.
8. If vaccination is withheld beyond the first year, unless smallpox exposure occurs, delay until the sixth year is advised to prevent accident. Similarly treatment during the summer months predisposes to secondary infection and other complications and should be avoided if possible.

THE MULTIPLE PRESSURE METHOD OF SMALLPOX VACCINATION

1. Moisten absorbent cotton with acetone and apply lightly to the deltoid insertion area of the left arm and allow acetone to dry.
2. Using aseptic technique, apply smallpox vaccine to this area.
3. Hold a sterile needle between the thumb and index fingers at about fifteen degrees to the transverse axis of the patient's arm. Tap an eighth inch area through the vaccine with the side and tip of the needle, using a down and forward stroke. Avoid bleeding as this tends to increase reaction. Within five minutes a small pink papule should appear at the site of vaccination.
4. Wipe off excess vaccine with sterile absorbent cotton.
5. Do not use a shield or dressing.

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MEDICAL SOCIETY OF VIRGINIA

PUBLIC RELATIONS

Some Activities.

Further consideration of policies and procedures of public relations were discussed at the Public Relations Committee meeting Friday night, February 28, at Rueger's Hotel. Attending the meeting were: Dr. J. M. Emmett, Dr. H. B Mulholland, Dr. A. L. Carson, Jr., for Dr. L. J. Roper, and Mr. Henry S. Johnson, Public Relations Director.

Attention was directed to the absolute necessity of a complete organization within the Medical Society before a successful Public Relations program could be expected. This, of course, refers to a District Councilor and Public Relations Representative for every component medical society, and a doctor in a similar capacity from every county in the state to serve under the direction of the Councilors for the respective districts. It was felt that the members of the District Council, in counties where no medical society existed, could do a great deal for Public Relations, and the medical profession of Virginia.

Since the topic for the high school debate, sponsored by the Virginia Literary and Athletic League, for this year is "Socialized Medicine", furnishing them with helpful materials was deemed timely.

Every possible effort is being exercised to set up and arrange for a radio program in several stations in Virginia. If this program, "Tell Me Doctor", can be worked out and scheduled with the various radio stations, it is hoped that it will be a five-minute transcription, perhaps five days a week (probably for a 13-week period). Cooperation and active assistance from component medical societies is essential in our final arrangements for this program with radio stations.

The matter of determining whether radio stations will accept "Tell Me Doctor" as a public service or if the time has to be purchased, and if so, the matter of finding sponsors who will pay for it, are some of the necessary problems we are working on.

A quiz on health and medical topics has been prepared for newspapers in the state. There appears to be considerable preference for this manner of presenting timely items to the public over the usual health column. As with the radio, the careful preparation of the material, with respect to authenticity, and the approval of our medical Censorship Committee, are essential. In addition, the problem of arranging for the publication of quizes constitutes a job of some proportions. We may suffer some disappointment in our efforts to work this out with the daily papers and find that we shall have to rely almost completely on weeklies. There is reasonable hope that a definite announcement of the beginning of this series can be made soon.

A barrage of requests have come to the Public Relations Office for a complete and up-to-date list of all of the doctors (and their location) in the state. Under the guidance of the Public Relations Committee, an attempt is being made to develop such a list from four sources. Local medical societies can be of great assistance in a final check before the list goes to print.

A more concise analysis of currently proposed legislation is another objective of the Public Relations Department. Two types have been suggested: the essay and the question and answer. If this can be done, it is believed it could very well serve as a supplement to information sent out by American Medical Association headquarters and the data supplied through the office of Dr. Joseph S. Lawrence, Washington, D. C.

The Director of Public Relations is continuing his efforts to meet every request to appear before local medical societies, and welcomes every opportunity to meet with any medical society or lay group that may be scheduled.

Outline of the Results of the Public Relations Committee Meeting, January 7, 1947.

I. CONTACT WITH MEDICAL SOCIETIES IN THE STATE

A. Through the Councilor find out what county and component societies there are in each district.

B. Request the Councilors to give us the names of the members of their respective District Councils. (We should inform all members of the District Council of their appointment if they are not aware of this.) We should also furnish information and materials on the December 19 meeting to each member of the Council and the District Council who do not have this.

C. We should remind each Councilor to complete his list of members of the District Council within his district.

D. These members of the District Council should be regarded, at least for the present, as those upon whom we should depend for assistance in public relations work within the Component Societies.

E. This representative should be furnished a kit of materials to distribute in his society. He can let the main office know what materials he wants and the quantity. ("Check and Double Check" and "Voluntary Sickness Insurance vs. Compulsory Insurance" were considered valuable.)

F. The Public Relations Committee has instructed the Director of Public Relations to urge each Councilor to call a meeting of his District Council. It was also the thinking of the Public Relations Committee that the Director of Public Relations should plan to meet with all such conferences, if possible. It was recommended that the Councilors be requested to send in to the Director of Public Relations the dates of these conferences, and that Councilors be advised that the Public Relations Committee was requesting the Director

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of Public Relations to attend the above mentioned meetings.

II. RADIO

A. The Public Relations Committee agreed we should try to secure the services of Mrs. Turnage for a period of sixty days to act as Radio Consultant on a part-time basis at a salary of one hundred dollars ($100) a month. It appears to be the general agreement that at the end of forty-five days of the above mentioned period we should be in a position to decide whether or not we wish to continue this arrangement with Mrs. Turnage.

1. It was the committee's opinion that Mrs. Turnage should prepare scripts for fifteen-minute transcriptions on several subjects, such as:
   a. High school debate subject of the year
   b. Prepayment medical care plans, etc.
2. And, in addition, submit script of approximately five-minute periods on appropriate subjects.

B. It was suggested that we attempt to make this material so valuable and attractive that the radio stations would be glad to schedule it as a public service. In the event we were unable to do this, it was thought best to try to get a state-wide sponsor for all ten stations, and if this failed our next effort should be to get local sponsors.

C. The Committee felt that we should determine if five-minute transcriptions used by the Michigan Medical Association were available to us, assuming, of course, that these were in each particular, applicable to Virginia. They favored the five-minute program (daily), if this could be arranged, over the fifteen-minute programs put on less frequently.

D. In order to facilitate our efforts to get medical censorship for our radio, press, literature and any publications, the Committee directed that the following Richmond doctors be requested to serve on the Board of Censors: Dr. Wyndham B. Blanton, Dr. J. Morrison Hutcheson, Dr. L. J. Roper, Dr. M. Pierce Rucker, and Dr. Carrington Williams. It was ordered that these men be contacted and requested to serve in this capacity. The Committee was quite willing to assume the responsibility for the content of materials going out of the Public Relations office, but felt that these, after put in final form, should be subject to close medical censorship.

III. NEWS RELEASES

A. The belief was expressed that news releases could usually well be centered around events and medical happenings of news value. It was suggested that we try to get news items on meetings of medical societies.

B. An article on the growth and overall coverage of medical care plans written in an interesting feature story manner was suggested for possible submission to newspapers and magazines. (The Virginia Education Association has already requested this as regards teachers.)

1. This article might include information as to the workings of the different plans with new and future developments.
2. It might also include information on how the population can get the plans and what the plan will do for them.

IV. ORGANIZATIONS, AGENCIES, AND INTERESTS THE DIRECTOR SHOULD CONTACT

A. It was suggested that a second letter should be sent to all medical societies reminding them that the Director of Public Relations is available to speak with them.

B. The importance of contacts with lay groups by the Director for information about the medical profession's activities was brought out and the following suggestions were made:

1. The Director was requested to contact public welfare groups, who seem to be most hostile to our present system of medical care; also Home Economics groups, farm bureaus, etc.
2. The desirability of having public relations men and other representatives from various organizations and interests outside the medical profession sit in with medical groups more often was expressed.
3. It was suggested that the Public Relations Director might accept invitations to talk with groups of medical students, nurses, dentists, pharmacists, etc.
4. Contacts with the above mentioned groups would serve as an excellent means of distributing literature received in great quantities.

C. It was agreed that notices be placed in the VIRGINIA MEDICAL MONTHLY as a reminder of the availability of the Director of Public Relations to any component or local medical society, as well as any lay group.

V. THREE MAJOR PROJECTS ARE:

A. Radio, discussed above.

B. Press, discussed above.

C. Appearances before lay groups

1. It was recommended that a meeting be scheduled at least once a year by each medical society centered about the problems of the medical societies, and the solution of these. It was pointed out that if local medical societies find difficulty in providing a speaker, the Office of Public Relations, with the Committee's help, would be glad to assist, if requested.
2. The belief was expressed that speakers provided should be men interested in and sure of their subject to serve without compensation, rather than the employment of outstanding orators.

VENEREAL DISEASE CONTROL COMMITTEE

The Venereal Disease Control Committee of the Medical Society of Virginia held a meeting at the Commonwealth Club, Richmond, on March 6th, with the following present: Dr. W. W. S. Butler, *chairman,* and Drs. E. M. Holmes, R. D. Kimbrough, James W. Love, D. S. Garner and E. E. Barksdale. Dr. D. C. Smith was the only member of the Committee unable to attend. The following report has been submitted as a result of this meeting:

PART I

The Committee discussed the recent laboratory evaluation study conducted by the State Health Department under the terms of the Virginia Premarital Examination Act. As sixteen laboratories had failed, the Committee recommended that these laboratories be given temporary approval under the following terms:

1. That Mrs. Elsie Foxhall, chief of the serology section of the State Health Department Laboratory, visit and laboratories that failed, to check their equipment. and test procedures.
2. That technicians from the failing laboratories come to the State Health Department for one week's observation and inspection in serodiagnostic methods.
3. That these laboratories be sent 25 specimens, 10 non-syphilitics and 15 syphilitics for evaluation.

PART II

The Committee discussed the advisability of recommending ambulant treatment with penicillin, oil and beeswax for syphilis and recommended that for the present and possibly subject to change at a later date that early lesion syphilis (primary, secondary and mucocutaneous relapse) be treated as follows: In public clinics located in large cities, the patients will be given 600,000 units a day for 5 days. In private practice lesion syphilis will be treated with one of the two following schedules:

1. Six hundred thousand units of penicillin, oil and beeswax a day for 10 days or 300,000 units of penicillin, oil and beeswax, a day for 18 or 20 days
2. That non-lesion syphilis (latent) be treated with 600,000 units of penicillin, oil and beeswax daily for 10 days.

In the management of lesion syphilis (primary and secondary) and non-lesion syphilis it is recommended that the State Health Department furnish POB to private physicians free of charge for the treatment of indigent and submarginal income patients. Further, it is recommended that this drug only be released upon the receipt of a morbidity report on which the physician lists the patient's complete name, color, sex, age and address, and signifies his willingness to have the patient interviewed for sexual contacts. This recommendation, of course, is contingent upon the approval of the budget committee of the State Health Department.

For the treatment of late syphilis, the following schedule was recommended; 8,000,000 units of POB given in 10 to 20 doses; in the management of individuals in the cardiovascular age group to avoid severe reactions, the patient should either be initiated into treatment with bismuth subsalicylate given intra-muscularly twice a week for 4 weeks or initiated with a fractional dose of 1,000 Oxford units of aqueous penicillin sodium every two hours. The committee did not recommend free penicillin for late syphilis at this time.

The committee did not recommend the concomitant use of arsenic and bismuth but stated that they felt that arsenicals and bismuth should be reserved for treatment failure and if administered should be given under the 26 weekly modified intensive arsenic-bismuth therapy schedule. The committee further stated that with our present knowledge it is believed that in the treatment of early lesion and non-lesion syphilis, penicillin should be given a thorough trial first because it is safe and quick.. The patient should be observed and followed up carefully for evidence of failure of cure. The physician after failures can, if necessary, resort to arsenic-bismuth and fever therapy. The exceptions to straight penicillin therapy without arsenic-bismuth and fever therapy are interstitial keratitis, optic atrophy and possibly some of the other varieties of neuro-syphilis.

The Committee further recommended that all penicillin treated patients be followed up on the following schedule: Monthly physical inspection examinations and quantitative serologic tests for the first year. Inspection and quantitative tests on the 15th month, 18th month, 24th month and annually for the next three years. It was also recommended that all penicillin treated patients be given a spinal fluid examination within three to six months after completion of treatment.

PART III

The Committee recommended that the State Health Department survey the two rapid treatment centers, one located in Richmond and the other in Norfolk, for the purpose of deciding—first, whether both of these institutions should be kept open after July 1, 1947, and secondly, whether the State should take these institutions over from the Federal Government. It was the opinion of the Committee that rapid treatment under hospitalization is an essential in the State control program to care for patients from the rural areas, as it is believed that ambulant treatment would not be practical without prohibitive cost in patient follow-up in such areas. It was further recommended that the medical students from the Medical College of Virginia and the University of Virginia, visit the center or centers if both are kept open for observation in the clinical management of syphilis under hospitalization.

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REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION

In accordance with action taken at the San Francisco Session of the American Medical Association, the House of Delegates held its first interim meeting at the headquarters of the Association in Chicago, December 9 to 11, 1946. Attendance was most gratifying, and a large volume of business was transacted.

Of primary importance was consideration of the public relations of the Association, and this centered around the Rich report which had been presented in part at the previous meeting of the House. Copies of the complete report were furnished all delegates and, after ample time for individual study, the report was laid before the House, acting as a committee of the whole for final disposition. Most of the recommendations embodied in the report were adopted with or without modification. These attempt to further systematize the work of the Association and to clarify the objectives and responsibilities of the various councils and bureaus, and to give greater emphasis to public relations. Certain recommendations previously adopted had already been put into effect. There is in the headquarters of the Association a division of public relations under an executive assistant to the General Manager, which will have charge of all public relations activities of the Association. Action was deferred on a recommendation concerning the relationship of the American Medical Association and the National Physicians Committee, and a special committee was authorized for the purpose of giving this subject further study. At the same time, the House expressed its unwillingness to go as far in initiating legislation as was recommended in the Rich report.

As scheduled, a report was received from a committee appointed at the previous regular session on revision of the constitution and by-laws. This brought discussion and suggestions from various delegates but no final action. The committee was instructed to continue its study and report at the next general session. One significant change in the by-laws was adopted, deleting from Chapter IV, Section 1, on Nominations the last sentence: "No member of the House of Delegates nor general officer of the Association shall be eligible for election to the office of President-elect or Vice-President." This provision has been circumvented by resignation a number of times in the past and seems unnecessary.

The Council on Medical Service reported a steady increase in the number of plans for prepayment medical care, and in enrollment in these plans throughout the country. As of November 1, 1946, the seal of acceptance had been granted to twenty-seven Medical Society approved plans. Developed only in the past few years, it is expected that enrollment in these plans will reach five million early this year. The Council continues active in assisting localities in the various phases of developing and publicizing this undertaking.

The Council on Medical Service wishes to impress on the State Medical Society the necessity of preparing a plan of cooperation for putting into effect the provisions of the Hill-Burton Bill. The Council is preparing a statement of principles to be used as a guide to such cooperation and a set of minimal standards for diagnostic clinic facilities. These suggested principles may be found on page 1014, volume 132, December 21, 1946 issue of the *Journal* of the American Medical Association.

A resolution was offered by Dr. Hammer, Delegate from Indiana, requesting that the American Medical Association sponsor a National Conference of officers of County Medical Societies. This resolution was favorably received and the American Medical Association is sponsoring such a meeting, which is to be held in Atlantic City on June 9th, and to which all officers of all state medical societies are to be invited. This should be an important meeting.

There was considerable discussion with reference to the bill to be introduced by Senator Taft in Congress after the first of the year. It was understood that such a bill would provide for grants in aid to States for medical care of the indigent. Conferences between members of the medical profession and Senator Taft were to take place sometime during the holidays. It was urged that all physicians familiarize themselves with the important bills being introduced which would have a bearing on the practice of medicine.

An interesting address by Admiral Boone dealt with the medical care of miners. Admiral Boone heads a government commission to study the hospital and medical facilities, medical treatment, sanitary and housing conditions in the coal mining areas. The purpose of this survey is to determine the character and scope of improvements which should be made to provide the mine workers of the nation with medical, housing and sanitary facilities conforming to recognized American standards.

A resolution which would permit members of the permanent corps of the Veterans Administration to apply for fellowship in the American Medical Association was introduced and received favorable consideration. As this would involve change in the constitution, no action could be taken until the next meeting of the Association.

Several resolutions concerning the practices of the various specialty boards were considered and discussed but no specific action taken. It was recommended that certification by a board be not held a requirement for staff membership in approved hospitals. It was also recommended that hospitals encourage the establishment of general practitioner services and that the existence of such services shall not prevent approval of hospitals for the training of internes and residents.

A resolution condemning the political activity of the

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Surgeon General of the Public Health Service evoked rather warm discussion. It was charged that this officer in a specific directive to members of his corps had supported the cause of socialized medicine. The House of Delegates went on record as expressing complete disapproval of this conduct of the Surgeon General.

In the addresses and remarks of officers and delegates, a feeling of optimism over the changed political situation was noticable; but there was no agreement that the threat of socialized medicine which has darkened the deliberations of medical societies for so many years, has passed. A preliminary report from the Committee on Centennial Celebration indicated that this committee is perfecting a most comprehensive and impressive program for the meeting at Atlantic City next June.

H. B. MULHOLLAND
J. MORRISON HUTCHESON

THE FORUM

Simplified Ganglion Removal Technique.

Complete removal of a ganglion is a very difficult procedure when the entire ganglion is dissected free from the surrounding tissue, which may involve nerves, blood vessels, and tendons. Occasionally when one is removed the tendon sheath is found to have also been removed, which may cause trouble. The ones that originate between the carpal bones are still more difficult to remove completely. I have never found a patient willing to cooperate in trying the Family Bible technique of rupturing a ganglion, so have no personal information on the efficacy of this treatment.

For the last few years, I have used the following technique successfully:

The ganglion area is prepared in the usual manner and infiltrated with novocaine. A longitudinal incision is made down to the ganglion and skin retracted over the domed surface. An incision is then made into the ganglion and contents expressed. The thin whitish membrane which composes the lining of the ganglion is then grasped with a hemostat and removed by blunt dissection using a small curved hemostat as a dissector. As a general rule this membrane is easily removed. Since this membrane is the seat of the trouble, removal of same cures the condition. The remaining portion of the ganglion is not disturbed, so this eliminates considerable dissection and also keeps the operative field practically bloodless. The skin is closed in any desired manner. To my knowledge there have been no recurrences in approximately twenty-five cases in which this technique has been used.

NORMAN G. PATTERSON, M.D.,
Bristol, Tennessee.
306 Light and Power Bldg.

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President..... MRS. J. E. HAMNER, Petersburg
President-Elect..... MRS. J. L. DECORMIS, Accomac
Recording Secretary..... MRS. M. H. HARRIS, West Point
Corresponding Secretary,
MRS. MEADE EDMUNDS, Petersburg
Treasurer..... MRS. REUBEN SIMMS, Richmond
Editorial Chairman..MRS. E. HOLLAND TROWER, Eastville

Do You Expect to Attend the National Meeting?

A few more months and the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, New Jersey, for their Annual Convention—June 9-13.

Have you made your reservations? If not, send your request at once to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, New Jersey.

Dr. Hamner.

It is with regret that we announce the death of Dr. J. E. Hamner of Petersburg, husband of the President of the Auxiliary to the State Society. We extend our sympathy to her and her family.

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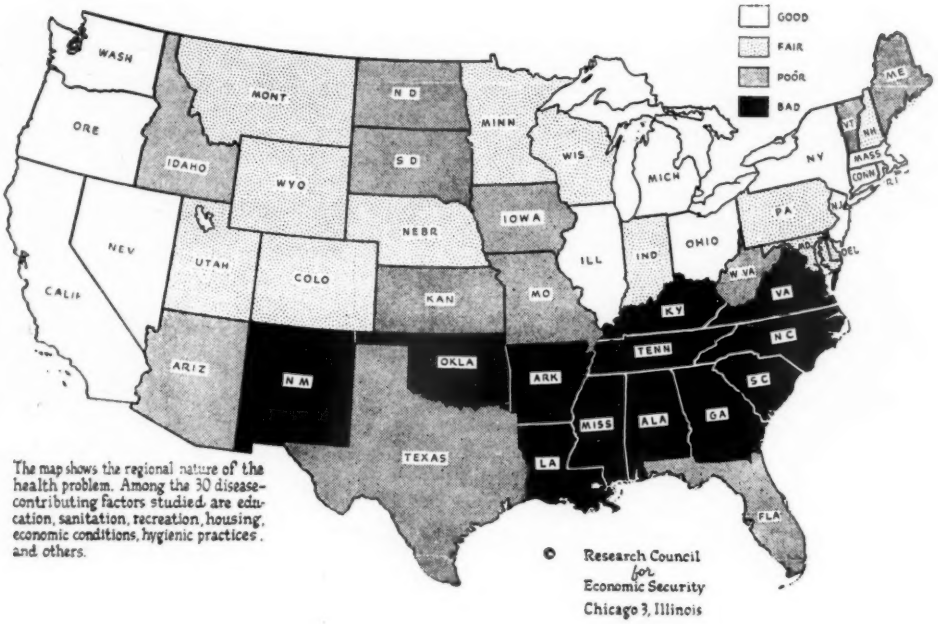
EDITORIAL

Our National Health Problem



Tuberculosis

IN 1940 when the data on which the map was made was published, Virginia had 58.8 resident deaths from tuberculosis per 100,000 population as compared with 46.1 deaths in the country as a whole. This rate was exceeded by only six states, Arizona, New Mexico, Kentucky, Tennessee, Maryland and Texas, and of these the first two are tuberculosis resort states. By 1944 Virginia had reduced her death rate to 40.2. In 1945 she was seventh from the highest among the states, if you excluded Arizona, New Mexico and the District of Columbia. It is estimated that there are about 15,000 cases now in Virginia with thousands in daily contact with them.

The Virginia Tuberculosis Association, which was organized in 1909 by Drs. Ennion G. Williams, W. F. Drewry, E. C. Levy and the Reverend J. T. Mastin, for educational purposes and to inaugurate special movements in particular communities, has issued a very informative report for the "Committee to Study Tuberculosis", of the "Virginia Advisory Legislative Council of the State of Virginia". This gives in an authoritative manner what has been done for tuberculosis in Virginia, what is being done, and what needs to be done. Virginia has 1.33 beds per death, whereas the Committee on Sanatorium Standards of the National Tuberculosis Association recommends 2½ beds per death. In this connection there is a waiting list for infirmary treatment of 284 persons. Perhaps the greatest need at present is more doctors and nurses so that existing beds will not remain unoccupied.

Among the recommendations of the Virginia Tuberculosis Association are: (1) A full time director, trained in public health and having a special knowledge of tubercu-

losis, who, under the supervision of the Commissioner of Health, shall have authority over the State sanatoria and over all tuberculosis field work. (2) Provision for adequate sanatorium care for all citizens needing treatment. This is to include facilities for major surgery within the sanatorium. (3) The encouragement of the fullest use of State sanatoria as training centers in tuberculosis. (4) Pre-employment and periodic x-ray examination of teachers and other school personnel, and the extension of mass x-ray examinations to school children, industrial and other groups. It is interesting to note that at present the Board of Health and the State Board of Education are undertaking an experimental demonstration study in five counties, in which all school children are to be x-rayed at least twice in their school life. All adults who come in contact with these children are to be x-rayed also.

Measures adequate to control tuberculosis "cost money, but cost less money than the consequent burden on the people caused by failure to make proper appropriation." As it stands now tuberculosis is the greatest killer among our people from the ages of fifteen to forty-five.

Eye Bank for Sight Restoration, Inc.

DR. DERRICK VAIL in an editorial in the *American Journal of Ophthalmology* for June 1946, gives an interesting progress report. The Eye Bank is now on a sound basis. It was legally incorporated in February 1945, "to carry on, directly or indirectly, such research, experimentation, etc., as may be reasonably calculated to be of value in saving, restoring, aiding, or preserving eyesight or in helping to prevent or avoid blindness or impairment of vision of any sort or to ameliorate the condition of the blind or those with defective eyesight; to maintain laboratories, clearing houses of information and the like for this purpose. . . . To aid, freely and voluntarily, in any manner which may be permitted by law, by loan, guaranty, grant, scholarship, fellowship, subsidy or otherwise any corporation or any surgeon, physician, scientist or student engaged in saving, restoring, aiding, helping to prevent or avoid blindness, or in whose work or welfare the corporation may have any other lawful interest. . . ." Thus it is seen that its powers are quite broad. At present it is actively engaged in furnishing eyes wherever needed and in training ophthalmologists in performing corneal transplants.

The American Red Cross and the airlines loyally contribute their services so that now all that one needs to do is to get in touch with the Eye Bank and an eye, sterile and preserved, is immediately shipped by air or messenger. In spite of this rapid transportation, regional branches are needed to complement and augment the work. Such a branch has recently been established in Chicago under the direct control of the Chicago Ophthalmological Society. The branch enjoys the support and legal backing of the Eye Bank. Surplus material that is not used within 12 to 24 hours is forwarded to New York. Calls on Chicago from the midwest that can not be satisfied are referred to New York. Information in regard to the technique of the Eye Bank can be obtained from the Eye Bank for Sight Restoration, Inc., 210 East 64th Street, New York.

The Eye Bank also has an educational program. Last year it awarded seven scholarships to ophthalmologists for training in the technique of the corneal grafting operation. This program is designed to obviate the necessity of the blind patient taking a long, expensive journey for his operation.

To see a patient whose sight has been restored by a corneal transplant gives one a peculiar thrill. Such experiences have been quite rare in the past. Until now it was

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well nigh impossible to get the material and the patient together. Then, too, few ophthalmic surgeons have been trained in the meticulous, though relatively simple, technique of the corneal grafting operation. More power to the Eye Bank in its thrilling work!

North Carolina State Medical Society Meets in Virginia

FOR the first time in history the Medical Society of the State of North Carolina will meet in Virginia. The dates of this historical occasion are May 12, 13, and 14, and the place is Virginia Beach. The leading editorial of the *North Carolina Medical Journal* for February explains why Virginia is to be thus honored. At its last annual meeting the Society voted to return to Pinehurst for this year's meeting. After the meeting was over the manager of the Carolina Hotel notified Secretary McMillan that he could not permit the Society to meet there in 1947. Since then Dr. McMillan has done all that is humanly possible to find a suitable meeting place in North Carolina, but has been forced to find accommodations outside the State.

Good meeting places for medical societies are becoming scarcer and scarcer. Hardly more than half a dozen cities in the United States can take care of the annual meeting of the American Medical Association. The Southern Medical Association is having the same difficulty and twice has had to meet outside its own territory. State Societies are growing so big that they, too, are having trouble. There are not more than three places in Virginia that can adequately take care of the annual meeting of the Medical Society of Virginia. Special societies also have their troubles. With a membership of from 100 to 200, and an attendance of perhaps one hundred, they do not appeal to the large convention places, and their demands in the way of meeting place and living accommodations are too exacting for the smaller resort hotels. For instance, the American Gynecological Society this year is meeting in the only place that was available for the usual time of its annual meeting. The American Association of Obstetricians, Gynecologists and Abdominal Surgeons has found it necessary to arrange for its annual meeting two years in advance.

In the matter of meeting places for medical meetings, Virginia, with its Hot Springs, Colonial Williamsburg, Virginia Beach, Richmond and Roanoke, is more fortunate than most States. She can take care of all but the largest medical meetings, and she rejoices in being in a position of being helpful to her sister State. North Carolina and Virginia doctors have the same background and their problems, traditions and ideals are identical. Nothing but a poorly marked State-line separates them. We welcome our brothers of North Carolina to our State for their annual meeting and predict that they will feel as much at home as if they were meeting amid the beautiful long leaf pines.

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SOCIETIES

Virginia State Board of Medical Examiners.

The following doctors were granted certificates by the State Board of Medical Examiners as a result of examinations held in Richmond in December 1946:

BY EXAMINATION

Dr. Richard Norton Baylor, Richmond.
Dr. James Harry Bocock, Norfolk.
Dr. David J. Cornick (Col.), Norfolk.
Dr. Anthony Francis Distefano, Portsmouth.
Dr. David M. Dumville, Richmond.
Dr. Edward M. Eppes, III, Richmond.
Dr. Abraham Jack Freund, Richmond.
Dr. Robert Emerson Fultz, Richmond.
Dr. Robert Ellsworth Gibson, Charleston, W. Va.
Dr. Michael I. Hanna, Holden, W. Va.
Dr. Mann Terrell Lowry, Sampson, New York.
Dr. Martin Markowitz, Richmond.
Dr. Ben Thomas Painter, Williamsburg.
Dr. Joseph E. Pisano, Brookneal.
Dr. William C. Robertson, Norfolk.
Dr. Olindo W. Rosanelli, Norfolk.
Dr. Franklin C. Turner, Richmond.
Dr. Richard Kennon Williams, Richmond.

BY RECIPROCITY

Dr. William Morris Anderson, Richmond.
Dr. George Stephen Appleby, Martinsburg, W. Va.
Dr. Sidney Raymond Arnold, Amherst.
Dr. James Paul Bailey, Hampton.
Dr. Barnwell Rhett Baker, Winchester.
Dr. Charles William Beaven, Newsport News.
Dr. Richard E. Bower, Richlands.
Dr. Barrington H. Bowser (Col.), Richmond.
Dr. Julius Charles Breme, Purcellville.
Dr. James Graham Brown, Norfolk.
Dr. Samuel Walthall Budd, Jr., Richmond.
Dr. Philip Burka, Washington, D. C.
Dr. James Anthony Campbell, Jr., Roanoke.
Dr. John Winston Capps (Col.), Hampton.
Dr. John Paul Carter, Washington, D. C.
Dr. W. Smott Carter, Middleburg.
Dr. Gordon G. Carmichael, Roanoke.
Dr. Francis Sinclair Chance, Marion.
Dr. Daniel Duncan Chiles, Radford.
Dr. Maynard Irving Cohen, Washington, D. C.
Dr. Lee Marion Cole, Jr., Christianburg.
Dr. Harold F. Corson, Richmond.
Dr. Richard W. Crossen, Richmond.
Dr. Julius Daniel Damian, Arlington.
Dr. Alfred A. J. Den, Washington, D. C.
Dr. Michael P. DeVito, Washington, D. C.
Dr. Michael George Dewey, Hampton.
Dr. Arthur Dick, Washington, D. C.
Dr. Robert H. Duenner, Newark, Del.
Dr. Frank F. Ellis, Jr., Lynchburg.
Dr. Mark Exley, Norfolk.
Dr. Joseph Edwin Faingold, Roanoke.
Dr. Henry Bennett Fletcher, Arlington.
Dr. Maurice Winfield Frazier (Col.), Washington, D. C.
Dr. Paul Edmund Halter, Alexandria.
Dr. Eddie W. Harris, Jr. (Col.), Petersburg.
Dr. William Henry Harris, Jr., Richmond.
Dr. Rose S. Hartman, Norfolk.
Dr. Kathryn Hill, Virginia Beach.
Dr. T. Wiley Hodges, Richmond.
Dr. Ebbe Curtis Hoff, Richmond.
Dr. Oswald Warrington Hoffler (Col.), Washington, D. C.
Dr. George G. Hollins, Jr., Norfolk.
Dr. William Howard Hosfield, West Point.
Dr. Herbert Saul Jackman, Richmond.
Dr. Robert Ernest James, Arlington.
Dr. C. Frederick Johnston, Jr., Grundy.
Dr. Granville L. Jones, Williamsburg.
Dr. Lorraine L. Jones (Col.), Farmville.
Dr. Harry James Jordan, Arlington.
Dr. William H. Kelly, Norfolk.
Dr. Lambert Joseph Kerschgens, Steubenville, Ohio.
Dr. George Morris Kersey (Col.), Atlanta, Ga.
Dr. Meyer I. Krischer, Norfolk.
Dr. Lillian P. Kravis, Arlington.
Dr. Charles E. Law, Alexandria.
Dr. Joseph D. Lea, Norfolk.
Dr. John B. Leary, Arlington.
Dr. Allen Edwin LeHew, Clifton Forge.
Dr. Robert Charles Livingstone, Petersburg.
Dr. John Louzan, Alexandria.
Dr. James Murdock MacMillan, Richmond.
Dr. Stephen Mamick, White Sulphur Springs, W. Va.
Dr. John Orburn Marcy, Bristol, Tenn.
Dr. Frank Maresh, Catawba Sanatorium.
Dr. Thomas Adrian Martin, Petersburg.
Dr. Ernest James McCampbell, Williamsburg.
Dr. Charles E. McKeown, Richmond.
Dr. Benjamin Miller, Newport News.
Dr. Thomas James Moran, Danville.
Dr. Leon I. Nathanson, Alexandria.
Dr. Bernard Notes, Washington, D. C.
Dr. Samuel O. Payne (Col.), Fredericksburg.
Dr. Leroy S. Pearce, Lynchburg.
Dr. Azelie Winifred Phillips (Col.), Petersburg.
Dr. Samuel Pillar, Roanoke.
Dr. Elbert Hugo Pogue (Col.), Bedford.
Dr. Homer Hayden Price, Fieldale.
Dr. Joseph James Quarles, Jr. (Col.), Norfolk.
Dr. Joseph Archer Ravenel, Martinsville.
Dr. Ernest S. Roberts, Hampton.
Dr. Eric C. Schelin, Richmond.
Dr. Albert F. Schmidt, Norfolk.
Dr. Seymour Schotz, Richmond.
Dr. Elmer Charles Schultz, Charlottesville.
Dr. Raymond Schwartz, Arlington.
Dr. C. Waldo Scott, Washington, D. C.

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Dr. John S. Selden, Jr. (Col.), Norfolk.
Dr. Alvin Seltzer, Washington, D. C.
Dr. June Carol Shafer, Arlington.
Dr. Henrik W. Shelley, Chincoteague Island.
Dr. Claude Porter Sherman, Martinsville.
Dr. Sigmund Henry Smedal, Alexandria.
Dr. Charles G. Souder, Leesburg.
Dr. William Conrad Stone, Roanoke.
Dr. George Foster Sutherland, Big Stone Gap.
Dr. Frank William Sutterlin, Bristol.
Dr. Forrest M. Swisher, Arlington.
Dr. Francis D. Threadgill, Washington, D. C.
Dr. Frederick Preston Titus, Baltimore, Md.
Dr. Eulyss Robert Troxler, Roanoke.
Dr. Deane Harold Vance, Washington, D. C.
Dr. Robert Browning Venner, Virginia Beach.
Dr. Harold E. Wager, Charlottesville.
Dr. Joseph E. Warren, Lynchburg.
Dr. Fred Cecil Watson, Los Angeles, Calif. (Intended Petersburg)
Dr. Robert C. Wesley (Col.), Petersburg.
Dr. William James White, Arlington.
Dr. LeRoy Ellwood Wible, Pittsburgh, Pa.
Dr. Franklin S. Wilcox, Radford.
Dr. William Byrd Wiley, Norfolk.
Dr. Prentiss Willson, Jr., Arlington.
Dr. Thomas H. Weaver, Alexandria.
Dr. Jacob Joseph Weinstein, Washington, D. C.
Dr. W. Eugene Wolcott, Warrenton.
Dr. Oscar D. Yarbrough, Clifton.
Dr. Samuel W. Doskof, Alexandria. Certificate not actually issued because applicant had incomplete credentials.

Richmond Academy of Medicine.

The Section of the Academy on the History of Medicine held its annual meeting in the Academy Building on the evening of March the 11th, to which were invited wives of the members of Academy. Dr. Alexander G. Brown, Jr., chairman, presided. Papers presented were:

Medical Service in the United States Army in World War II—Colonel Joseph H. McNinch, M.C., from the Office of the Surgeon General, Washington, D. C., and

An International Drama—Dr. John Bell Williams, Richmond.

The scientific program was followed by an informal reception in the dining room.

Dr. Harry J. Warthen was elected chairman of this Section for the coming year, with Dr. A. S. Brinkley as vice-chairman, and Dr. Ennion S. Williams as secretary-treasurer.

Albemarle County Medical Society.

At the meeting of this Society on March 6th, Dr. George Cooper of Charlottesville was elected secretary to succeed Dr. C. Marshall Lee, Jr., resigned.

Danville-Pittsylvania Academy of Medicine.

The following are officers of the Academy who were elected to serve for the year 1947: President, Dr. M. H. Watson; vice-president, Dr. Snowden C. Hall; secretary-treasurer, Dr. M. H. McClintic. All are of Danville.

Bedford County Medical Society.

Officers of this Society elected for the year 1947 are: President, Dr. W. G. Hardy; vice-president, Dr. E. L. Johnson; and secretary-treasurer, Dr. William V. Rucker, all of Bedford.

Roanoke Academy of Medicine.

At the March meeting of the Academy, Dr. E. M. Holmes, Director, State Venereal Disease Control, Richmond, spoke on "The Problems of Penicillin Therapy in Venereal Disease"; Dr. J. N. Dudley, Roanoke, on "Activities of Local Health Department"; and Dr. Linwood D. Keyser, also of Roanoke, on "Advances in the Treatment of Urinary Calculi".

Dr. Charles A. Young is president of the Academy and Dr. W. H. Saunders, secretary-treasurer.

Virginia Peninsula Academy of Medicine.

Dr. Charles Troland, associate professor of neurosurgery of the Medical College of Virginia, Richmond, addressed the Academy at its regular meeting on March 17th. His subject was "Acute Head Trauma".

There was an attendance of sixty-five and Dr. Robert Wright, Phoebus, presided.

CHESTER D. BRADLEY, *Secretary-Treasurer.*

NEWS

State Society Meeting.

The Council set dates for the next meeting of the Medical Society of Virginia in Roanoke as October 13, 14 and 15, with headquarters at Hotel Roanoke. Other hotels in Roanoke are the Patrick Henry and the Ponce de Leon, both of which are in walking distance of headquarters. It is recommended that those expecting to attend should make reservations promptly. Dr. Frank Farmer is general chairman of the Committee on Arrangements and has the following doctors assisting him:

Dr. George S. Hurt—Hotels and Halls.

Dr. Charles Peterson—Entertainment.
Dr. David Garner—Commercial Exhibits.
Dr. W. W. S. Butler—Scientific Exhibits.

In looking over records, it was found that this will be the 100th meeting of the Medical Society of Virginia, there having been several gaps in times of meeting since the organization of the original Society in December 1820, so this will be the Centennial meeting. It is hoped that members will make reservations promptly and help make this one of the biggest meetings of the Society.

News from the University of Virginia, Department of Medicine.

On February 7th and 8th the National Conference on Rural Health held its second annual meeting in Chicago. Dr. H. B. Mulholland, Professor of Medicine, was co-chairman of the round table discussion, "Methods of Bringing and Holding Physicians and Dentists in Rural Areas".

Dr. William Gayle Crutchfield, Professor of Neurological Surgery, spoke before the Fifteenth Annual Assembly of the Southeastern Surgical Congress in Louisville, Kentucky, on March 10th, on "Surgical Treatment of Hypertension".

On January 28th Dr. Samuel Alexander Vest, Jr., Professor of Urology, spoke before the New Jersey Summit County Medical Society on "Prostatic Cancer". On February 24th, he held several clinics at the seminar at the University of Alabama and was guest speaker on "Male Endocrinology".

The Phi Beta Pi Medical Fraternity had Dr. Harold L. Stewart of the National Cancer Institute on March 21st as guest speaker. Dr. Stewart spoke on "Experimental Gastrointestinal Cancer".

Heads American Cancer Society.

At the meeting of this Society in Chicago, early in March, Dr. Edwin P. Lehman was elected president, succeeding Dr. Frank E. Adair of New York City. Dr. Lehman is professor of surgery and gynecology at the University of Virginia, Department of Medicine, and has been most active in the fight against cancer in Virginia.

Dr. William Eickers,

Richmond, was guest speaker at the regular monthly meeting of the Fayette County Medical Society, Montgomery, W. Va., on March the 7th, his topic being "Disorders of Menstruation".

The American Public Health Association

Announces its 75th annual meeting as taking place in Atlantic City, New Jersey, October 6-10, inclusive, 1947. Helping the Association to celebrate its 75th annual meeting will be the following organizations: American School Health Association; Association of Maternal and Child Health Directors; Association of Reserve Officers of the U. S. Public Health Service; Association of State and Territorial Health Officers; Conference of Municipal Public Health Engineers; Conference of Professors of Preventive Medicine; Conference of State and Provincial Public Health Laboratory Directors; Conference of State Directors of Health Education; Conference of State Directors of Public Health Nursing; Conference of State Sanitary Engineers; National Committee of Health Council Executives; Public Health Cancer Association.

Exhibits and the scientific program will point up progress in public health over a 75 year span.

Dr. Blalock Heads Mental Hygiene Society.

At the eleventh annual meeting of this Society, held in Richmond on March 5th, Dr. Joseph Blalock, superintendent of the Southwestern State Hospital, Marion, was elected president, and Mr. F. W. Gwaltney, Richmond, was re-elected executive secretary.

Army Medical Library Microfilm Service.

During the war, the Army Medical Library through its photoduplication services supplied millions of pages of microfilmed medical articles to the Armed Services and other Research Agencies. This service is now generally available for civilian physicians, institutions and research workers on a cost basis. This means direct access to the library's enormous resources of medical literature.

A fee of fifty cents is charged for filming any periodical article in a single volume, regardless of length. Microfilming from monographs is furnished at fifty cents for fifty pages or fraction thereof. Photostats are also available at a charge of fifty cents per ten pages or fraction thereof. Material filmed is not for reproduction without permission of the copyright owner.

For convenience and to keep bookkeeping costs down, a coupon system has been established. Users may buy any quantity of photoduplication coupons at fifty cents each. Order blanks are available upon request. Checks should be made payable to the

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Treasurer of the United States, and sent to the Army Medical Library, 7th St. and Independence Ave., S.W., Washington 25, D. C.

Quarterly Review of Obstetrics and Gynecology—New Editor.

We are pleased to note that Dr. Bayard Carter of Duke University has succeeded the late Dr. Howard Kane as Editor-in-Chief of the *Quarterly Review of Obstetrics and Gynecology*. This will insure a continuation of the high standard of this useful review in this important field.

In this connection we might call attention to the latest member of the great group of Reviews that are published by the Washington Institute of Medicine, i.e., the *Quarterly Review of Psychiatry and Neurology*, which is now starting its second volume. The Editor-in-Chief of this is Winfred Overholser, M.D. The other quarterly reviews of this publisher are ophthalmology, Surgery, Radiology, Otorhinolaryngology and Broncho-Esophagology, Allergy and Applied Immunology, Pediatrics, Urology, Medicine, Dermatology and Syphilology, and General Practice Clinics. The latter is edited and designed for the general practitioner, and has perhaps a more impressive editorial board than any of the *reviews*.

Dr. C. Marshall Lee, Jr.,

Of Charlottesville, has accepted an offer to join the permanent staff of the Norburn Hospital, Asheville, N. C., and entered upon his work there the first of April.

Duke University School of Medicine.

The Duke Medical Alumni will hold their second reunion on April 24-26, in Durham, N. C. The following program has been prepared, with the graduates and those who trained at Duke to give the papers.

THURSDAY MORNING—APRIL 24TH

Registration.

THURSDAY AFTERNOON

Dr. O. J. Bateman, '39—"Use of A.A.L. in Gold Poisoning".

Dr. Charles Styron, '38—"The Genito-Urinary System in Diabetes Mellitus".

Dr. George Harrell, '36—"Plasma Volume and Extra-Vascular Thiocyanate Space in Rickettsial Spotted Fever".

Dr. B. B. Dalton, '32—"Meeting the Problems of the General Practitioner".

Dr. P. B. Parsons, '36—"Intra-abdominal Herniation. Its Radiological Diagnosis".

Mock Clinic (by Junior and Senior students).

Class and/or Departmental entertainment.

FRIDAY—APRIL 25TH

Dr. George Gilbert—House officer 1939-41—"The Cellular Changes in Carcinoma of the Prostate Following Hormonal Therapy".

Dr. Paul Reque, '34—"An Evaluation of the Use of Antibiotics in Dermatology".

Dr. J. S. Hiatt, Jr., '40—"Pneumoperitoneum in the Treatment of Pulmonary Tuberculosis".

Dr. David Wilson, House officer 1942-46—"Lucite Balls in the Treatment of Pulmonary Tuberculosis".

Dr. Harold H. Kuhn, '40—"Open Versus Closed Treatment of Acute Osteomyelitis".

Exhibits.

Business Meeting.

Presentation of New Officers.

Reunion of 65th General Hospital and 38th Evacuation Hospital.

Open House—Local Alumni.

Dinner-Dance—Hope Valley Country Club.

SATURDAY, APRIL 26TH

Dr. Eleanor Easley, '34—"A Study of Maternal Morbidity with the Use of Caudal Anesthesia".

Dr. Robert H. Pudenz, '35—"Cranial Trauma and Brain Movement. Direct Observation of the Brain with High Speed Cinematography".

Dr. R. H. Rigdon, House officer 1931-35—"Consideration of the Mechanisms by which a Rapid Diminution Occurs in the Parasitemia in Ducks Infected with P. lophurae".

Dr. David A. Young, House officer 1935—Title later.

Dr. Charles W. Hock, '41—"Radiation Injuries of the Intestines".

Duke-Navy Baseball game.

Dr. Chester D. Bradley,

Formerly associated with Dr. Waverly R. Payne and Dr. Harvey G. Bland of Newport News, announces the removal of his practice to offices on West Avenue at 30th Street. His work will be limited to Obstetrics and Gynecology.

Dr. Charles F. James,

Class of '38, Medical College of Virginia, announces the opening of his office for the practice of general surgery in Washington Square Building, Tallahassee, Florida. He has recently been released from service in the Army.

The Yater Clinic

Has recently been opened in Washington, D. C., at 1801 K Street, Northwest, with the following staff:

INTERNAL MEDICINE

Wallace M. Yater, M.D.
Joseph M. Barker, M.D.
Bernard E. Nunez, M.D.
Bertram F. Schaefer, M.D.
Joseph J. Wallace, M.D.

DERMATOLOGY-SYPHILOLOGY
Edwin E. Barksdale, M.D.

PEDIATRICS
Catharine Knop, M.D.

PHYSICAL MEDICINE
Gervase J. P. Barger, M.D.

GENERAL SURGERY
Robert J. Coffey, M.D.

GYNECOLOGY-OBSTETRICS
Carlton N. Price, M.D.

UROLOGY
Leon R. Culbertson, M.D.

PROCTOLOGY
Vincent T. Yeung, M.D.

OPHTHALMOLOGY
William H. Hanna, M.D.

OTOLARYNGOLOGY
Joseph M. Daly, M.D.

Medical Officers Wanted.

The U. S. Civil Service Commission has announced an examination for filling Medical Officer positions. These positions are located in various Federal agencies, in Washington, D. C.; in the U. S. Public Health Service and the Indian Service, throughout the United States; and in the Panama Canal Service, in the Panama Canal Zone. Salaries range from $4,149 to $5,905 a year, with higher salary rates for the Canal Zone positions. No written test will be given for these positions. To qualify, all applicants must be graduates of a medical school of recognized standing and must also meet other requirements which include experience and training in the field of medicine. The age limits are 45 years for Panama Canal Zone positions and 62 years for other positions.

Interested persons may secure information and application forms from most first- and second-class post offices, from Civil Service regional offices, or from the U. S. Civil Service Commission, Washington 25, D. C. Applications must be filed not later than April 22, 1947.

American College of Chest Physicians.

The thirteenth annual meeting of the American College of Chest Physicians is scheduled to be held at the Ambassador Hotel, Atlantic City, New Jersey, June 5 to 8. An interesting scientific program has been planned for this meeting. Prominent speakers from other countries will present papers.

The oral and written examinations for Fellowship will be held on the first day of the meeting, June 5. Applicants for Fellowship in the College who plan to take these examinations should communicate *at once* with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Convocation for new Fellows and Life Members of the College will be held on Sunday, June 8. At this time certificates will be awarded to Fellows and Life Members admitted since June 1946.

Dr. S. E. Massey

Has returned to Wytheville for the Spring and Summer, after spending the winter in Lakeland, Florida.

Dr. G. C. Godwin,

Who has been with the Richmond City Health Department for the past sixteen months as Tuberculosis Control Director, whose duties included supervision of Pine Camp, the city's tuberculosis sanatorium, has resigned, effective April 30, to take a position with the VA tuberculosis hospital at Oteen, N. C.

For Sale—

McCaskey cabinette. Also a set of Fairbanks office scales. Both in good condition. Address "Doctor", 428 Shenandoah Road, Hampton, Va. (*Adv.*)

For Sale:

GE X-ray, Model 1775; 30 ma; 85 KVP, table with Bucky; in excellent working condition. James P. King, M.D., Radford, Va. (*Adv.*)

Doctor Wanted

In progressive and growing urban-rural community adjoining Richmond, without resident doctor since two have retired. Will give reasonable guarantee as to number of patients to serve. We welcome a visit. Any doctor interested please communicate with Varina Ruritan Club, E. P. Boyton, Secretary, Henrico County Court House, 22nd and Main Streets, Richmond, Va. (*Adv.*)

Doctors Needed in Rural Communities.

Many inquiries come to this office for doctors in rural communities. If interested in such, send your name to this journal, 1200 East Clay Street, Richmond 19, Va. (*Adv.*)

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OBITUARIES

Dr. John Aldridge Gibson,

Prominent physician of Leesburg, died March 9th after an illness of several weeks. He was seventy-one years of age and received his medical degree from the University of Maryland in 1901. Dr. Gibson had practiced in Loudoun County since 1903. He was a past president of the Leesburg Rotary Club and a member of the Loudoun County Hospital board of directors. At the time of his death he was president of the Loudoun County Medical Society. Dr. Gibson had been an active member of the Medical Society of Virginia since 1909, having served as vice-president and member of various committees. His wife, two daughters and a son survive him.

Dr. William Miller Holman,

Widely known physician of Goochland County, died February 22nd at his home in Richmond. He was eighty-seven years of age and a graduate of the Medical College of Virginia in 1890. Dr. Holman had practiced in Goochland County until his retirement last year and he had always taken an active part in the civic and religious affairs of the County. He had been a member of the Medical Society of Virginia for fifty-five years. His wife and nine daughters survive him.

Dr. John Edward Hamner,

Well known physician of Petersburg, died February 24th after an illness of six weeks. He was born in Amelia County in 1892 and graduated from the Medical College of Virginia in 1916. Dr. Hamner served in World War I with Base Hospital No. 45, following which he became a member of the staff of Central State Hospital in Petersburg. He then practiced for sometime in West Virginia, returning to Petersburg in 1934. Dr. Hamner was prominent in civic and medical affairs and was a member of the Medical Society of Virginia.

Dr. Hamner is survived by his wife, who is president of the Woman's Auxiliary to the Medical Society of Virginia, and by four children by a former marriage.

At a called meeting of the Petersburg Medical Faculty, held February 24, 1947, the following resolutions were presented and unanimously adopted:

First: Inasmuch as it has pleased Almighty God, our Heavenly Father, to take from our midst our friend and associate, Dr. John E. Hamner, while bowing to His Will, we deeply deplore our loss.

Second: That in the passing of Dr. John E. Hamner, our faculty has lost an extremely valuable member: one whose kindly manner, uniform courtesy, and general worth both as a man and a physician we all appreciated and will long remember.

Third: That we extend to his family our deepest sympathy.

Fourth: That a copy of these resolutions be sent to the family, included in the minutes of the Petersburg Medical Faculty, and published in the public press and in the VIRGINIA MEDICAL MONTHLY.

MUNFORD R. YATES, *President,*
Petersburg Medical Faculty.

Dr. James Henry Deyerle,

Prominent physician of Harrisonburg, died November 26, of coronary occlusion. He was seventy years of age and a graduate from the former University College of Medicine, Richmond, in 1901. He had been a member of the Medical Society of Virginia since that year. He had served as health officer of Harrisonburg and physician at Madison College, and also on the staff of Rockingham Memorial Hospital.

Dr. Charles R. Vance,

Bristol, Tenn., since 1900 a member of the Medical Society of Virginia, died February the 26th, at the age of seventy-nine. He was a graduate in medicine of the University of Virginia in 1891, and practiced in Norfolk until he moved to Bristol in 1935. His wife survives him.

Dr. William Samuel Scott,

Retired Navy medical officer of Richmond, was killed by a hit and run driver on March 6th. He was a native of Fredericksburg and fifty-two years of age. Dr. Scott received his medical degree from the University of Virginia in 1916 and enlisted in the U. S. Navy during World War I. His wife survives him.

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